MINISTRY OF HEALTH
DEPARTMENT OF HEALTH FOR SCOTLAND

Report of the Joint Working Party on the

Medical Staffing Structure in the Hospital Service

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To: The Rt. Hon. J. Enoch Powell, M.B.E., M.P., Minister of Health

The Rt. Hon. John S. Maclay, C.M.G., M.P., Secretary of State for Scotland.

Sirs,

I. Preface

1. In collaboration with the Joint Consultants Committee of the Royal Colleges, the Royal Scottish Corporations and the Central Consultants and Specialists Committee of the British Medical Association, the Minister of Health and the Secretary of State for Scotland appointed us in July, 1958, to study in the light of experience since 1948 and of all other relevant considerations the principles on which the medical staffing structure in the Hospital Service should be organised.

2. The decision to set up a Working Party was made urgent by the unfortunate position which had arisen by the training of too many senior registrars in medicine, surgery and obstetrics and gynaecology, but it immediately became apparent to us that the even greater problem was the provision of intermediate staff (between consultant and houseman) in non-teaching hospitals. This is not a problem peculiar to our health service for it exists in other parts of the world, including North America. As we are convinced of the necessity for posts at this level irrespective of training needs, there are only a few possible solutions to the problem of filling them, for instance to create posts of unlimited tenure (permanent career posts) at this level; to encourage men and women to remain longer in the hospital service before going into other branches of medicine; or to staff hospitals partly by men and women who are spending the rest of their time in general practice. We have examined all these possibilities.

3. The full Working Party has had 34 meetings. In addition there have been many meetings of groups of members deputed to consider particular matters. A large volume of written evidence has been received—a list of those by whom it has been submitted is given in Appendix 1—and after considering it we have in many cases discussed points arising from it with the authors. Some of the evidence submitted has gone beyond our province. For instance in some cases it has contained representations that new specialties should be recognised. This question is primarily for the profession, not for us. Our aim has been to confine ourselves to the staffing structure. From the outset we were clear that no worthwhile study of the present structure could be made solely by receiving and considering the views of interested administrative and medical bodies. In some measure the structure has been a subject of controversy from the start of the National Health Service and while the views of these bodies, and particularly their testimony on experience, would be indispensable, we were in no doubt that it would need to be supplemented by direct and personal study of the structure

and its working on the spot in different kinds of hospitals, teaching and non-teaching. Accordingly, teams of members, each consisting of a physician, a surgeon and an administrator, medical or lay, visited hospitals in various parts of England, Wales and Scotland. In the course of these visits the medical staffing structure as it works in particular hospitals has been discussed privately with members of the medical staff of all grades and with representatives of the hospital authorities responsible for the particular hospitals. Our first enquiries were concerned mainly with general medicine and general surgery. Later the needs of other specialties were examined by the teams. We have considered the systems of staffing in other countries. We desire to acknowledge our great indebtedness to all persons and bodies who have collaborated with us.

II. The Development of the Present Structure

THE STRUCTURE AS PICTURED BY THE SPENS COMMITTEE

4. The Spens Committee on the Remuneration of Consultants and Specialists reported in 1948* that until then medical students had normally qualified at the age of 23 or 24. After taking account of:

(*a*) the career picture of the past,

(*b*) the likelihood that the holding of pre-registration house appointments would soon become compulsory, and

(*c*) the long period of training required in some of the more specialised branches of medicine,

the Committee recommended the establishment of three grades above house officer for doctors in training for the special branches of medicine. Posts in these training grades were to be of limited tenure. Above them were to be posts of unlimited duration in the consultant grade. The Committee seem to have taken the view that in general the doctors between house officers and consultants would be those aspiring to consultant posts and that these doctors should, throughout their service in these intermediate grades, concentrate as trainees on one particular specialty.

5. The Spens Committee envisaged advance through the training grades being related to the length of time the practitioner had been registered, coupled with age. They pictured the following progression from the house officer grade:

(1)	Junior training post:	normally obtained not less than one year after registration and normally held for one year only.
(2)	Middle grade training post:	obtained normally not less than two years after registration and held normally for two years at the ages of 26 and 27.
(3)	Top grade training post:	obtained normally not less than four years after registration and held normally for three years at the ages of 28, 29 and 30.
(4)	Consultant post:	32 would be a normal age for attaining the grade.

*Report of the Interdepartmental Committee on the Remuneration of Consultants and Specialists (Cmd. 7420).

6. Though the Spens Committee appear to have supposed that the doctors in the three training grades would all be aspirants to consultant posts, the Committee clearly recognised that at each level there would be some who would not proceed to the next higher grade and apparently they assumed that these practitioners would readily find suitable openings outside the Hospital Service. Moreover, the Committee specifically indicated that a longer or shorter time than that stated in the definitions of the training grades might be spent in any of these grades. The Committee explained that:

> "by indicating a general standard related primarily to the length of time after registration, the definitions have regard to age, which at this stage of the specialist's career is a most important factor".

On the top grade training post the Committee made a special comment which is worth recalling. They said:

> "whilst realising the inadvisability of making it easier for individuals to prolong indefinitely their tenure of posts below those of full staff status, we think it necessary to safeguard the position of the fully trained registrar who is compelled to wait a limited time for a vacant staff appointment. At the same time, we wish to emphasise that in our opinion all possible steps should be taken by encouraging the interchange of specialists between hospitals to minimise and equalise this unavoidable waiting period."

SUBSEQUENT DEVELOPMENTS

7. *The "Spens" Grades.* The Terms and Conditions of Service of Hospital Medical Staff accepted by the profession at the commencement of the National Health Service provided for a structure which would include the grades envisaged by the Spens Committee. The three training grades were called junior registrar, registrar and senior registrar and were described in the same terms as were used by the Committee except that no reference was made to the ages at which registrar and senior registrar posts might be expected normally to be obtained.

8. *Introduction of other grades.* Following discussions upon the Spens Committee's Report between the Health Departments and representatives of the profession, the grades of senior hospital medical officer and junior hospital medical officer, both of unrestricted tenure, were added to the grades envisaged by the Committee.

9. The grade of senior hospital medical officer was inserted in the structure immediately below the consultant grade on the view that a grade of unlimited tenure was required at this level to meet:

(*a*) an immediate need to find a place in the staffing structure for a number of doctors transferred to the new service who were not trainees but who had not the training and standing necessary to justify grading them as consultants. These doctors were mostly transferred with local authority hospitals and many had been working in special fields of medicine, e.g. tuberculosis. Some were general practitioners who had been holding part-time appointments at their local hospitals;

(*b*) a more permanent need for doctors below consultant grade to perform work of limited scope, of lower responsibility and requiring less skill than that of the consultants, at least in some specialties and in some hospitals, and in appointments which should not be of limited duration like those of senior registrars.

In the Terms and Conditions of Service, senior hospital medical officers are described as senior officers performing clinical duties who are not of consultant status but are not in the registrar grades.

10. A fuller statement on the scope of the grade is contained in a circular which the Ministry of Health sent to regional hospital boards and boards of governors in 1950. This circular is reproduced in Appendix 2. It showed that what was envisaged was the employment in certain specialties of senior medical officers assisting consultants—reference was made to assistant anaesthetist, assistant pathologist and assistant radiologist—for the purpose of carrying out the more routine and less responsible work. In some specialties, however, no place was seen for assistants of this kind. These specialties were general medicine, general surgery (including urology and proctology), obstetrics and gynaecology (practised together), cardiology, dermatology, otolaryngology, neurology, neurosurgery, plastic surgery and thoracic surgery.

11. The junior hospital medical officer grade was introduced to meet a similar need for a grade at a lower level originally for doctors transferred to the Hospital Service in junior appointments of unlimited tenure, mainly assistant medical officers at local authority mental hospitals. Appointments to it are now not always of unrestricted tenure; many are made for specified periods, e.g. for some time new appointments in Welsh hospitals have been made for a limited period of three years. In the Terms and Conditions of Service the grade is described as consisting of "officers who have held house appointments but who are not registrars and who have less responsibility than other hospital officers of non-consultant status, and who have been appointed for a limited or an indefinite period."

12. A few years ago it was agreed between the Ministry of Health and the Joint Consultants Committee that pending the outcome of the general discussions on the staffing structure already in progress, hospitals with large casualty departments might be authorised to appoint a senior casualty officer for a term of four years on a salary scale within the range of that applicable to senior hospital medical officers.

13. Provision was also made at the outset for the participation of general practitioners in hospital work as members of the staff of general practitioner (cottage) hospitals or as part-time clinical assistants or part-time medical officers at other hospitals and at convalescent homes. The arrangements also allowed of a doctor spending part of his time in general practice and part in hospital work as a consultant or senior hospital medical officer if his training and experience justified it.

14. *Modification of the original concept of particular grades.* The National Health Service had not been in existence very long before the concept of the grades between house officer and senior registrar as being grades primarily for training future consultants had to be abandoned. In 1950, hospital authorities were told that the junior registrar should not be regarded as being essentially a trainee for a consultant or senior hospital medical officer post and the name of the grade was changed to senior house officer to avoid confusion with the registrar grades. The next year the registrar grade (as distinct from the senior registrar grade) ceased, after discussions between the Health Departments and

the Joint Consultants Committee, to be looked upon as primarily a training grade.

15. In the Terms and Conditions of Service the grades of senior house officer and registrar continued to be defined as consisting of posts normally obtained not less than one year after registration and held normally for one year in the case of the grade of senior house officer (formerly junior registrar), and normally obtained not less than two years after registration and held normally for two years in the case of the grade of registrar. In practice, however, the total period of service in the grades has commonly exceeded the period envisaged by the Terms and Conditions as being that for which a particular post would be held. We have been told that most regional hospital boards keep good registrars as long as they wish to stay. The only effective remnant of the definitions in the Terms and Conditions of Service is the condition that the posts may not normally be obtained less than one year or two years as the case may be after provisional registration. The posts are not necessarily graded according to the nature of the work to be done. Where difficulty is experienced in filling a house officer post it is not uncommon for it to be transferred to the senior house officer grade in the hope that the higher salary will attract applicants. Similarly we have met instances of the regrading of a post as junior hospital medical officer because the greater security and higher and rising salary of this grade proved more attractive than the conditions of the senior house officer grade.

16. *The tenure of senior registrar posts.* In 1951 the normal period of tenure of a senior registrar post was lengthened to four years from the original three years as part of the measures taken to deal with the large surplus of senior registrars that had been trained. At present, however, even this longer limitation on tenure is in abeyance pending the outcome of our work.

17. *Age of qualification.* Information supplied to the Ministry of Labour by University Joint Recruiting Boards showed that the age distribution of male medical students in Great Britain who were liable to National Service and were expected to complete their medical course in 1956-59 was as follows:

Year of Birth	Number expected to complete course in the calendar year			
	1956 (Information collected November 1955)	1957 (Information collected November 1956)	1958 (Information collected October 1957)	1959 (Information collected October 1958)
1929 or earlier	12	2	1	—
1930	49	18	3	—
1931	249	67	19	5
1932	423	245	63	8
1933	237*	450	261	53
1934	16	187*	457	280
1935	—	18	230*	527
1936	—	1	15	221*
1937	—	—	2	11
1938	—	—	—	2
Total	986	988	1,051	1,107

4,132

*indicates the age groups 22–23.

From the table it appears that of the 4,132 students liable to National Service who were expected to complete their course in those four years 875 or 21 per cent would be age 22—23, 1,857 or 45 per cent would be age 23—24 and 1,035 or 25 per cent would be age 24—25 on doing so. It is not to be supposed that the inclusion of the ex-service students and the others not liable for National Service, and of the women students, would reduce the age level or on the other hand would raise it significantly. Moreover a census of junior medical staff made at our request (to which further reference is made later) shows that of the 1,584 provisionally registered house officers employed at 31st March, 1960, who were born in Great Britain, 274 or 17 per cent were under 25 years of age and 1,070 or 68 per cent were in the age group 25—27 years. From the foregoing information it is reasonable to conclude that the normal age of qualification has increased from the 23 or 24 reported by the Spens Committee to approximately 23—25.

18. *The number and distribution of doctors in the various grades and specialties.* It is, of course, essential in examining the staffing structure to keep in mind the numbers in the various grades, and how they have changed relative to one another during the ten years or so in which the structure has been in operation. For this purpose the Health Departments have supplied us with the following statement of the number of doctors in the hospital grades at the end of the years 1949, 1953 and 1959:

GREAT BRITAIN

Numbers of Medical Staff

Grade	1949	1953	1959
Consultants	5,600	6,950	7,700
Senior Hospital Medical Officers	2,100	2,500	2,400
Senior Registrars	1,600	1,200	1,350
Registrars	1,950	2,250	3,150
Junior Hospital Medical Officers	450	650	850
Senior House Officers (Junior Registrars in 1949) ...	1,000	1,850	2,400
House Officers	3,250	3,100	3,100
Totals	15,950	18,500	20,950

Notes

(*a*) As some of the figures bave to be estimated, all are adjusted to the nearest 50.

(*b*) All 1949 figures, except those for consultants, are estimates. The figure for senior hospital medical officers for this year must be treated with reserve.

The 1953 and 1959 figures for senior hospital medical officers and senior registrars are estimates for the end of the respective years based on the actual numbers in the middle of the years.

The figures for the other grades are based on returns made by hospital authorities of the numbers of appointments in tbe grades. This being so there may be some duplication by reason of more than one part-time appointment heing held by the same doctor in the same grade, but as there are relatively few part-time appointments in these grades the figures as rounded in the tahle are thought to represent fairly closely the number of doctors employed.

(*c*) The figures for consultants, which include some employed by the Board of Control and the Public Health Laboratory Service, numbering 67 in 1959, exclude consultants ineligible for distinction awards. Those excluded are mainly consultants aged 70 or more holding honorary appointments. They are relatively few.

(*d*) There is a small amount of duplication between the figures for consultants, senior hospital medical officers and senior registrars owing to the fact that a few doctors hold part-time appointments concurrently in two of these grades.

(*e*) The figures do not include (*i*) general practitioners engaged in hospital work other than as the holders of appointments in the grades listed in the table (see paragraph 20); (*ii*) doctors employed as clinical teachers or in clinical research who though doing some hospital work do not hold paid or honorary appointments which are graded in the Hospital Service

(*f*) The figures do not include 3 senior casualty officers in 1953 and 57 in 1959. The origin of these officers has been explained in paragraph 12.

The figures indicate that over the ten years 1949 to 1959 the total number of doctors in the Hospital Service increased by about 30 per cent.

19. Information placed before us by the Health Departments of the age and specialty distribution of the doctors employed in the various grades is given in Appendix 3.

20. General practitioners holding part-time appointments in one or other of the usual grades are included in the figures in the foregoing table. There is no precise information about the total number of general practitioners working in the Hospital Service in that way or in some other capacity, e.g. as members of the staff of general practitioner cottage hospitals or general practitioner maternity hospitals, as clinical assistants or as part-time medical officers at convalescent homes. It is clear, however, that a considerable number are taking some part—though mostly a small one—in hospital work. Information available concerning the Birmingham Hospital Region indicates that general practitioner clinical assistants work 870 notional half-days weekly in hospitals in the Region, the equivalent of the wholetime service of some 79 doctors. It is not known how far this Region may be typical of others. If it is representative, then the equivalent of more than 800 wholetime doctors would be provided by general practitioners working in hospitals as clinical assistants.

III. General Experience since 1948 and some General Criticisms and Considerations

21. The fact that problems were arising in the staffing of the hospitals was apparent long before we were appointed and had led to investigation by the profession and discussion between the Health Departments and the profession. About the same time as the original concept of the grades of junior registrar (now senior house officer) and registrar as being grades primarily for training future consultants had to be abandoned it was recognised that the senior registrar grade, which was then the only remaining grade dedicated specifically to the training of future consultants, had grown to a far larger size in certain specialties than was warranted by the vacancies in consultant posts which were likely to arise in the near future. The excess of senior registrars, though now smaller, still persists and the problem presented by those doctors who have been

retained year after year in this grade after completing their training loomed large in the discussions which preceded our appointment. At the same time contentions have been common that by reason of inadequacies in consultant staffing members of grades below the consultant grade are undertaking consultant work and responsibility. Concurrently many non-teaching hospitals have been unable to attract sufficient doctors to build up adequate staffs of house officers and registrars.

22. In the evidence submitted to us there is a noteworthy absence of testimony that the present structure has proved satisfactory in all respects, or is the best that can be devised. On the contrary some criticism of it is expressed or implied in all the general evidence received, though there is no unanimity on its shortcomings or on how they should be remedied.

23. Some evidence reflects and supports the criticisms prevalent before our appointment. It indicts the structure of having failed to ensure adequate recruitment to all parts of the country and to all specialties; of having produced a surplus of senior registrars for whom there are not enough openings; and of bringing about a situation in which many practitioners in posts below consultant level are being obliged to carry consultant responsibility. Contentions have been advanced that the present structure below the consultant grade (and the senior hospital medical officer grade where the employment of doctors in this grade is permitted) is defective in that service is subordinated to training. Variants of this criticism are contained in the evidence put to us that in non-teaching hospitals the training needs of the doctors conflict with the staffing and service needs of the hospitals; and that the present structure, though suitable for teaching hospitals does not meet the needs of the non-teaching hospitals. Other criticism, founded on a similar view that in practice the structure works differently in teaching hospitals and in non-teaching hospitals, is directed to the fact that in most non-teaching hospitals there is a gap between the consultant on the one hand and the registrar (or sometimes the senior house officer) on the other which in teaching hospitals is filled by the senior registrar; and the suggestion is made that this gap equally needs to be filled in non-teaching hospitals.

24. A basic question raised by these criticisms is whether a structure designed for training in a specialty can effectively fulfil service needs. Training and service are here named in this order because the structure between the consultant grade and the house officer grade as visualised by the Spens Committee was expressly related to the needs of training for the special branches of medicine. From long before the report of the Spens Committee this had been the customary basis of staffing in the large voluntary hospitals. Though this conception has since been modified, in that the registrar grade and the senior house officer grade (formerly known as the junior registrar grade) are no longer officially recognised as existing primarily to afford such training—in the sense that the numbers in them are now related to the needs of the service rather than to the opportunities of promotion—appointments as registrar and senior house officer are temporary and still limited in the normal course to the short periods of two years and one year respectively. Moreover, it has been usual for doctors holding appointments in these grades to work in one and the same specialty throughout their service in the grade.

25. Appropriate as the limitations of tenure and the restriction of experience to one specialty may have been in a plan in which the primary purpose of the posts was to afford training in the special branches of medicine, these features are not necessarily appropriate when the primary purpose of the posts is the regular routine care of the patients. In practice the number of the appointments made in these grades in many specialties is such as to require far more doctors to fill them than the number who go on, and can expect to go on, to make a career as a consultant in the specialty. This has been the case ever since the National Health Service began. Essential as specialisation is for advancing to the consultant grade, if undertaken too early it may prove to be a positive disadvantage to the doctor who later turns to a branch of medicine other than hospital work for his career. For this reason, as well as in the interests of the best use of medical manpower, it should not be undertaken too soon nor carried to an advanced stage before the individual doctor can be reasonably sure of a worthwhile career in the chosen specialty.

26. Lest some of the comments in the last two paragraphs may be misunderstood, it should be made clear that we are not suggesting that learning and practice can be severed. We see no essential conflict between training and service needs. The question is whether the structure can be soundly based on assumptions that the two needs are always coincident and that what satisfies the first will always satisfy the second.

IV. General Principles upon which the Staffing Structure should be Founded.

27. In view of these general criticisms of the present structure there will be advantage in setting out at this early point in our report the general principles which in our opinion must form the foundation of a sound medical staffing structure in the Hospital Service in this country. We do so in the following paragraphs.

28. The structure must be based upon consultants since doctors of consultant rank are recognised—and are the only doctors so recognised in the Hospital Service—as being qualified by professional experience and training to take full personal responsibility for the complete medical care of all patients within their particular specialties. A consultant's appointment in the Hospital Service should not be limited in tenure save for a specified age of retirement.

29. The structure must further make provision for:

(i) doctors required to assist consultants in the day-to-day care of their patients;

(ii) doctors needing postgraduate experience and training in hospital as a preparation to their career whether in the Hospital Service or in another branch of medicine.

(i) and (ii) are not mutually exclusive. The provisionally registered house officers assist the doctors in charge of the patients concurrently with, and as part of, the process of obtaining the requisite postgraduate experience to qualify for full registration. Similarly with other house officers (including senior house officers) and registrars, the assistance they give is part of the process of acquiring further postgraduate experience and training.

30. The relationship of these assistants to a consultant must be such that the latter's personal responsibility for each of his patients remains clear. Whatever the assistants do for these patients must be done, and be openly recognised as being done, on behalf of and under the direction of the consultant.

31. The training aspect requires that many of the assistants' posts should be of limited tenure; for only so will sufficient openings be assured for (i) new graduates to enter the house officer grade so that they may qualify for full registration; (ii) fully registered doctors to obtain more experience in hospital either because they have a hospital career in view or because they will thereby be better fitted to follow a career in another branch of medicine.

32. Advancement from one grade to another should be competitive. It must therefore be recognised that some doctors who aspire to higher appointments in the Hospital Service will fail in the competition. On occasion these doctors may have become so specialised that this fact and their age become an obstacle to their obtaining suitable work in their profession outside the Hospital Service. By that time their experience and skills are, however, bound to be of such value to the Service that the structure should provide ways and means by which such doctors may be retained in it and on a permanent basis where appropriate.

33. A considerable proportion of doctors make their permanent careers in general practice and the structure of the Hospital Service should take account of this for two main reasons: (i) general practice, like other branches of medicine, depends for its new entrants on young doctors who first obtain some hospital experience; and (ii) it is in the interests of the Health Service as a whole that suitably qualified general practitioners should have duties in, and a regular connection with, hospitals. The structure should therefore provide suitable places for:

(*a*) the new graduates who require the hospital experience which is a prerequisite to full registration;

(*b*) the doctors who desire to obtain postgraduate experience over and above the minimum required for registration, whether or not they will be making their careers in the Hospital Service;

(*c*) suitably qualified doctors in other branches of medicine, especially general practice, to engage in hospital work for part of their time.

34. Having stated what seem to us to be general principles on which the staffing structure should be based, we now go on to examine the position in each of the grades of the present structure and indicate what changes seem to us to be required in the way these grades should be used.

V. The Consultant Grade

NUMBER AND DISTRIBUTION BY SPECIALTY AND AGE

35. The number of consultants increased from 5,610 to 7,680 in the ten years 1950—59, that is to say, by 2,070 or 37 per cent. The rate of increase was not constant. At the start of the National Health Service the doctors transferred to

it from the local authorities and the governing bodies of the voluntary hospitals had all to be assimilated into the national grading structure described above and an employing authority's decision on the grade into which a particular doctor should be placed was subject to a right of appeal. Later there was a general review of the grading of doctors who had not been graded as consultants but considered that they should have been. As a result the grading of many doctors transferred to the new service was not finally settled until 1951-52. Thus any comparison of increases in the numbers of consultants in the early years of the National Health Service is complicated by the fact that these increases were due, to a variable extent, to regradings of doctors already employed in the Hospital Service and not wholly to increases in the total number of doctors employed in the Service. Of the increase of 2,070 in 1950-59, no less than 1,140 took place in the three years 1950-52—an increase of 380 a year. Subsequent increases have varied but have never exceeded 200 in a year.

36. As a large proportion of the consultants work part-time only in the Hospital Service the increase in the number of consultants is not necessarily a full measure of the extent to which the amount of consultant time employed in the Service has increased. It would be so only if the average amount of time for which a part-time consultant is employed in the Hospital Service is constant. In fact it is not and it is now higher than at the beginning of the National Health Service. Consequently in 1950-59 the amount of consultant service employed measured in units of time increased by more than the 37 per cent by which the number of consultants increased.

37. The growth in the number of consultants has not been even as between one specialty and another. It will be noted from Table A in Appendix 3 that between 1952 and 1959 the increases in the medical specialties and the surgical specialties, as defined in that table, and in obstetrics and gynaecology, amounted to only 381 out of a total increase of 1,030, the 381 being made up as follows:

	Number	*Percentage increase over total number in the specialties at the end of* 1952
Medical specialties	208	11·2
Surgical specialties	137	5·8
Obstetrics and Gynaecology...	36	7·6

The other 649 was composed of the following increases in the other specialties:

	Number	*Percentage increase over total number in the specialties at the end of* 1952
Mental Illness and Mental Deficiency	158	27·9
Radiology and Radiotherapy	137	26·2
Pathology	199	34·2
Anaesthetics	155	21·7

38. The age distribution in 1958 (the latest date for which information is available) as compared with 1952 is shown in Table B and the accompanying diagram in Appendix 3. There was nothing approaching an even spread of consultants over the various age groups in either year.

39. The age distribution varies to some extent between one specialty and another. In Great Britain in 1957, the latest year for which separate figures are available for the various specialties, the proportion of the consultants who were below 46 years of age was as follows:

	Percentage of consultants in specialty below 46 years of age
Medical specialties	42
Surgical specialties	39
Obstetrics and Gynaecology	42
Mental Illness and Mental Deficiency ...	43
Radiology and Radiotherapy	53
Pathology	54
Anaesthetics	55

CONSULTANTS AND CONSULTANTS' WORK

40. There is no authoritative definition of a consultant or of consultant work. In general terms a consultant is a person who has been appointed by a statutory hospital authority by reason of his ability, qualifications, training and experience to undertake full personal responsibility for the investigation and/or treatment of patients in one or more hospitals without supervision in professional matters by any other person. This appointment is made after taking the advice of a mainly professional committee constituted in accordance with the statutory provisions. These appointments are made in connection with hospitals which treat patients whose illnesses are beyond the scope of general practice. The work which a consultant may properly delegate to assistants will depend on the experience and quality of the assistants and is normally left to the judgment of the consultant, who has to realise that his responsibility continues in spite of the delegation. This description is supplemented in paragraph 47 below by some guiding principles on consultant work.

EXCESSIVE OR INAPPROPRIATE DELEGATION OF CONSULTANT DUTIES

41. Evidence both from hospital authorities and from professional bodies indicates that under present arrangements work properly belonging to consultant posts is being regularly discharged by senior registrars and members of more junior grades. Further, it suggests that notwithstanding the increase in the number of consultants that has occurred under the National Health Service this number is still inadequate to the needs of the hospitals. Our own investigations confirm that this evidence is sound.

42. The factors responsible for this situation are complex. The influence of some has been general to the whole Hospital Service. These include:

(1) the financial restrictions to which hospital authorities are subject;

(2) inadequacies in accommodation and facilities, especially operating theatres and laboratories;

(3) lack of an adequate number of fully trained candidates for consultant vacancies in some specialties, e.g. mental health, radiology and anaesthetics.

Others have operated in individual cases. These include:

(1) mistakes in the grading of posts;

(2) local deficiencies in the organisation of consultant services;

(3) excessive delegation of responsibility by existing consultants;

(4) a resistance sometimes by hospital boards and sometimes by consultants to the creation of new consultant posts even when these are demonstrably needed;

(5) diffidence on the part of consultants to exercising supervision over other doctors who may be as well qualified academically as they are and may even have longer professional experience;

(6) the desire of doctors below consultant rank who have higher qualifications to take increasing responsibility and to show that they can safely be allowed to exercise full responsibility.

43. Before a hospital board in England and Wales may increase the total number of consultants employed in the board's hospitals the Minister of Health's approval to the proposed increase is normally required. Suggestions have been made that this requirement is being used by the Minister to prevent necessary expansion. We are satisfied that such suggestions are without foundation. On the applications made by boards for approval to an increase in their consultant establishments the Minister seeks the advice of a professional advisory committee consisting of some of his consultant advisers and of consultants nominated by the Joint Consultants Committee, under the chairmanship of one of his Deputy Chief Medical Officers. When the committee are satisfied that a proposed increase is justified they advise the Minister to this effect. When, as has sometimes happened, the number of proposed new consultant appointments in a specialty exceeds the number of senior registrars with adequate training in the specialty, the committee have advised that some of the proposed additional appointments should be deferred; otherwise the boards would be competing against one another for the available candidates to the detriment of those requiring additional consultant service in the least attractive areas where the need may be greatest. The committee's advice has invariably been accepted by the Minister. There is a corresponding procedure in Scotland under which regional boards' proposals for increases in the consultant establishment are the subject of consultation between the Department of Health and the Joint Consultants Committee (Scotland).

44. There is no need for us to attempt the invidious task of evaluating the influence of the several factors. There can be no question that the duties and responsibilities of a consultant post should be discharged as a regular thing by a consultant only and our concern therefore is to suggest ways and means by which this end may be achieved in future, rather than to discover how much of the responsibility for the present situation is due to this or that circumstance. Though it is partly a question of the number of consultant appointments, it is also partly a question of the organisation of consultant services. Some appointments regularly entail a disproportionate amount of travelling between hospitals. This is tantamount to consultant time being wasted. We have also met cases in which the consultants live so far from the hospitals in which they are responsible for patients as to make impossible their personal attendance in emergency.

45. In the previous paragraphs we have not dealt with the delegation of consultant work to senior hospital medical officers. They are in a special position because of the agreement of 1950 which is reproduced in Appendix 2. As a kind of "no detriment" arrangement this agreement specifically recognised that posts which were to be filled in future by consultants might, where already held by senior hospital medical officers, continue to be held by these officers until they retired or obtained other hospital appointments. The fact that the present duties of the posts may include, and indeed may largely or wholly consist of, consultant work is recognised by an agreement reached on the Medical Whitley Council in 1959 by which the senior hospital medical officers holding these posts are entitled to a special allowance at the rate of £550 per annum in addition to their ordinary salary where, with the authority of the employing hospital board, they are for all or most of their time undertaking work which after their tenure of the posts will be performed by consultants. This Whitley agreement was made pending and without prejudice to the outcome of our work.

GENERAL PRINCIPLES APPLICABLE TO CONSULTANT APPOINTMENTS

46. The making of a realistic assessment of consultant needs, which is an essential preliminary to the development of a properly organised and adequate structure, will be facilitated by supplementing the descriptions of a consultant and consultant work by a statement of the general principles which should apply to a consultant appointment.

47. These general principles should be as follows:

(1) All patients in the Hospital Service should be in the charge of consultants, and consultants in the specialty or specialties involved in the treatment of each patient should bear the responsibility for his care and the medical work required for him.*

(2) A consultant's obligations are not restricted to certain fixed sessions. Over and above his regular sessions he has an inescapable continuing responsibility for his patients at all times. This applies to inpatients, outpatients, to urgent and non-urgent cases alike.

(3) Doctors below consultant rank should act as assistants to the consultants in the discharge of their responsibilities. The extent to which duties and responsibilities are delegated to the assistants will vary between specialties, and, in a particular unit, it will vary from time to time according to the seniority and experience of the doctors available to help the consultant. The consultant's overall and personal responsibility for his patients continues in spite of such delegation.

(4) The time that a consultant devotes to any given hospital should be sufficient to enable these responsibilities to be discharged. Thus outpatient and operating sessions should be adequate, and visits and ward rounds as frequent as may be necessary for the proper care of patients. In hospitals largely concerned with the treatment of acute illness, the

*The Working Party realise that for the time being an occasional exception will have to be made in the case of consultant posts filled by senior hospital medical officers (see paragraph 150). Where this is so a consultant's opinion should always be available. Reference is made in paragraph 139 to the special position in general practitioner units.

aim should be for every inpatient to be seen by the responsible consultant at least two or three times a week. Outpatient arrangements should be such that junior staff are not left in sole charge, except in the occasional unavoidable absence of the consultant.

(5) Some consultants, while prepared to devote substantially the whole of their time to hospital work and to give it priority on all occasions, prefer a maximum part-time contract, that is, one for nine notional half-days work per week, to a wholetime contract. It has been accepted that subject always to the needs of the Hospital Service employing boards should in this matter take into account the circumstances and preferences of the consultants concerned. Past practice should continue. Apart from those cases in which a wholetime or a maximum part-time contract is equally justifiable, there are many cases where the services of a consultant are needed in the aggregate for only a limited volume of work and where therefore an appointment for part-time service is the only appropriate basis of employment. Where practicable, however, small part-time appointments should be absorbed into the duties of existing staff or, failing that, should be grouped together to form appointments for a worthwhile amount of time.

(6) The work of a consultant should be confined to as few hospitals as circumstances will permit. In any event he should have a main attachment to one hospital or hospital centre in which most of his time will be spent. His contract should be framed with this object in view. He should live within easy reach of his main hospital or hospital centre. He should make pastoral visits as necessary to outlying hospitals, including cottage hospitals.

(7) The duties required of each consultant should be defined with precision in his contract.

These general principles were first formulated by us in relation to consultant appointments in general medicine and general surgery. The examination of the other specialties which we have made since they were framed has shown that in essence they are equally applicable to them. While the nature of the work in some of these other specialties is such that there is no question of the consultants undertaking treatment and therefore of having charge of patients, e.g. diagnostic radiology and pathology, the work which is done for patients should nonetheless be accepted as being the responsibility of consultants. A possible exception is refraction in ophthalmology when undertaken by a doctor who has no other hospital work in the specialty. The foregoing statement of principles should be read in this sense.

ORGANISATION OF CONSULTANTS' SERVICE

48. *The "firm" system.* The fact that a consultant has his own patients for whom he has full responsibility must not be taken as implying that he should carry on his hospital work on an entirely independent basis where there are other consultants in the same specialty at the same hospital. We believe that at present this fact is not sufficiently recognised. Too often is each new consultant appointed as an independent individual.

49. Though in some hospitals the employment of more than one consultant in a specialty is not justifiable, where two or more are employed there is everything to be said for bringing them into a relationship (*a*) which will facilitate the provision of continuous and effective consultant cover for all patients in the specialty, emergencies as well as others, between the consultants' regular visits and when one of them is away on holiday or for some other reasons; and (b) which will pay some regard in the distribution of work to the factor of seniority in the consultant grade so that the work is distributed in such a way that the younger consultants do more of the physically more strenuous work, such as the treatment of emergencies or the paying of extra visits to hospital at short notice or at night, though not to the extent that the juniors do the whole of the emergency work.

50. The "firm" system is a long established and tried method of meeting many of these needs. It is widely used in teaching hospitals and it has been adopted in some non-teaching hospitals. Usually it takes the form of grouping the consultants in one specialty into pairs, a senior and a junior, status in this respect being determined by length of service only. Movement from junior to senior status is usually automatic and dependent solely upon seniority and retirement. Naturally it occurs later in some cases than in others owing to accidents of age but this is not of serious moment as the juniors have the same clinical status as the seniors.

51. With a staff organised in this way a firm can work as a unit, the younger consultant carrying the same clinical responsibilities as his senior and enjoying the same clinical independence but assuming a greater burden of the physically more strenuous work. The two consultants on a firm can consult and work together and assist one another in any way that they agree. When one is on leave the other remains on duty. Where there are two or more firms the different firms can rotate on emergency duty, one doing duty on certain days in each week and another on other days or one performing a whole week of emergency duty—the so-called "take-in" week—and another similarly doing a whole week at a time. There is scope for other co-ordination between firms. Thus beds could be allocated in specific numbers to each firm, or each consultant, but firms on emergency duty could "borrow" beds from other firms when needed or a medical firm borrow from a surgical or vice versa. The system secures that the consultants of a firm know at all times when they are responsible for emergency admissions and when they are free from this responsibility. It recognises the fact that a consultant's range of duties when he is young and junior may not be the same as when he is older and more senior.

52. It almost goes without saying that where two or more consultants in the same specialty are on the staff of a hospital, the closest working relationship should be developed between them. The staffing pattern in consultant appointments depends, however, on many factors, including local tradition and we should be the last to suggest that it can and should conform blindly to a standard pattern whatever the circumstances. But in general better and more efficient service can be given where consultant work is organised on the firm system than where it is organised on the basis of individual consultants each working independently; for not only can emergency and holiday duties be shared but more

efficient use can be made of junior staff. Though the system operates already in many hospitals we believe that there are many other hospitals where it could be introduced with advantage.

53. Essentially a firm should consist of two or more consultants in the same specialty working together as partners. There should be no distinction between them in the matter of clinical status. All should have full consultant responsibilities and be paid as consultants. From mere length of service on the staff one would, however, be first or senior partner of the firm. Where several firms exist in the same hospital the senior of the junior partners should usually become head of a firm when one of the senior partners retires. Some regrouping of the partners in all firms may need to be made on such an occasion.

54. Although the junior member may undertake a greater part of the emergency work, all members should contribute to providing continuous consultant cover and it will fall to the first or senior member to make satisfactory arrangements to this end in collaboration with his fellow member or members. The preparation of a rota for emergency duties would no doubt be included in those arrangements.

55. Where two or more consultants in one specialty are working at the same hospital there is a presumption in favour of their forming a firm. It is not, however, to be supposed that the possibility of forming a firm with advantage exists only in such a case. It exists also where the consultants are individually associated with different hospitals, provided the hospitals are reasonably accessible one from the other. Moreover, though firms are most common in general medicine and general surgery, the scope for them is not limited to these specialties. There are examples of their successful organisation in most other specialties. The possibility of advantage being derived from their formation should be examined wherever there are two or more consultants in one specialty at one hospital, or two or more hospitals so situated as to permit of both or all of them being served efficiently by a firm.

56. Where there is need for more consultant service to be available but there is not scope for another consultant with responsibility for a substantial proportion of the beds, it may be that the need can be met through a variant of the firm system. In such a case the necessary relief might properly be provided by associating with the existing consultant or consultants, another doctor of consultant rank. Accordingly we consider that it should be recognised that, where local needs so require, a doctor may be appointed as a consultant but on condition that he will work for the time being in supplementing the work of the consultant or consultants with whom he is associated. In essence he would become the junior partner of a firm. When there is difficulty in providing effective consultant cover for holidays such an arrangement may offer a solution. The supplementary consultant should not, however, be employed entirely for relief duties. He should always be given some beds as of right. While deputising during holidays for other consultants might form an express part of his duties, this should not remove from these other consultants their responsibility for sharing holiday work when circumstances permit. The supplementary consultant should be appointed in open competition like any other consultant. It should be provided

in his contract that on a consultant vacancy arising in the hospital or hospital group in which he is serving, or if subsequent development there permits, he will be given a full number of beds and a normal range of consultant duties. Like any other junior member of a firm he should be employed on the terms and conditions of service of consultants. The need for such a consultant may be greatest where there is a disproportionate amount of outpatient work or of pastoral visiting.

57. *The question of defining the appropriate work-load for a firm.* We have devoted much consideration to the question whether some guidance can be given about the amount of work that a firm of two consultants may be expected to undertake. There is, however, no escape from the fact that the formulation of a precise work-load which will be universally applicable and reasonable is impracticable. The capacity of the individual consultants and of their assistants inevitably varies. The nature of cases treated differs from one hospital to another, as also does the standard of facilities for their care. The number of inpatients for whom a consultant can be responsible is bound to be affected by the amount of his outpatient work, and vice versa. The non-teaching hospitals to which visits were paid in the course of our study of general medicine and general surgery showed wide variations in the amount of work associated with the same number of occupied beds (i.e. inpatients) in these specialties in 1957. The following table shows the extremes in the case of these hospitals, together with the average of non-teaching hospitals in England and Wales, of outpatient work (and, in surgery, of operations also) associated with 80 occupied beds in each instance:

1957

	Weekly Numbers of Outpatients	
General Medicine	*New*	*Old*
Hospital A (maximum)	83	267
Hospital B (minimum)	23	90
All non-teaching hospitals—England and Wales ...	30	93

	Weekly Numbers of Outpatients and Operations		
	Outpatients		*Operations*
General Surgery	*New*	*Old*	
Hospital C (maximum)	84	176	125
Hospital D (minimum)	17	21	38
All non-teaching hospitals—England and Wales	45	98	Not known

In addition to the time spent with patients account must also be taken of such duties as letter writing, consultation with colleagues, deputising for absent colleagues, emergencies, etc. The reasonable work-load for a particular firm can only be assessed by reference to the various individual and local factors mentioned above. As advised by our clinician members on the basis of their experience and discussion with consultants in the course of visits to non-teaching hospitals we can go no further than to say that in acute units in general medicine and general surgery in present circumstances a firm of two wholetime or maxi-

mum part-time consultants assisted by a registrar or a doctor of similar experience and qualifications and two housemen might be expected to be able to take responsibility for 60—80 inpatients with the associated outpatient and emergency duties. Wholetime and maximum part-time service are taken as alternatives in this context. The number may, however, vary considerably with local conditions and the type of work undertaken and it may well need to be smaller in teaching hospitals. It will need to be smaller for some other specialties, e.g. neurology and neurosurgery, because of the special complexities of the work. On the other hand in others where the inpatients include long-stay patients who require little by way of regular specialist treatment it will be considerably higher. In yet others, such as dermatology and physical medicine in which the work is predominantly concerned with outpatients, a work load expressed in terms of inpatients only would be inappropriate, as it would also be for the specialties not directly responsible for treating patients. Further the ratio of junior staff to consultants will often be less in these other specialties than in general medicine and general surgery.

VI. The Senior Registrar Grade

58. We turn to this grade next because of its special relationship to the consultant grade.

THE TRAINING PLAN

59. It was implicit in the original concept of the senior registrar, registrar and junior registrar (now senior house officer) grades as all being training grades, that the number of practitioners in all three grades would be related to the expectations of vacancies in the consultant grade (as well, later, as in the senior hospital medical officer grade in the specialties in which new appointments in this grade were permissible). Thus the size of each of the training grades would have been more or less strictly controlled. The senior registrar grade is the only training grade now continuing in that sense. As it was found that its size could not be satisfactorily related to likely vacancies for those completing training by leaving the individual hospital boards to decide independently how many senior registrar posts they should have, in 1951 control of the number of posts was assumed by the Ministry of Health in England and Wales and by the Department of Health in Scotland. It was at this time that the recognised term of service in the grade was extended to four years from the original three.

60. The Health Departments estimate that the number of senior registrars in 1951 was approximately:

England and Wales	1,400
Scotland	200
Total—Great Britain ...	1,600

On the basis of a normal term of service in the grade being four years, the Ministry of Health came to the conclusion at that time that the need for trained candidates for vacancies in the higher medical grades for the next few years called for a complement of 960* senior registrars for England and Wales—some

*This figure covered a relatively small requirement for dentistry also.

400 fewer than were already employed. When this figure was being formulated account was taken of the likely losses in the consultant and senior hospital medical officer grades from retirement and death, and allowance was made for expansion in these grades, for wastage from the senior registrar grade during the first three years of training, for the need to maintain a proper degree of competition for the vacancies in the higher grades, and for some emigration amongst senior registrars. The 960 posts were spread as follows over the four years of training:

First year	—	270
Second year	—	250
Third year	—	230
Fourth year	—	210

It will be noted that this plan assumed a wastage during training of 60, or just over 20 per cent of the total annual number of new entrants to the grade. When telling the hospital boards of the plan the Minister of Health mentioned that he had come to the conclusion that over the next few years the number of vacancies likely to be available for senior registrars both in this country and elsewhere might not fall far short of 200 per annum. As the plan visualised there being 210 senior registrars who would each year complete a full training of four years, the view appears to have been taken that an adequate degree of competition for the higher posts would be secured by having on average not many more than 10 in 200 fully trained senior registrars in excess of immediate requirements.

61. When the plan was settled the hospital boards were told how many senior registrars in each specialty they might employ and they were asked to reduce as soon as possible the number they were employing to bring it into accord with the plan. Many vacancies for consultants were occurring at this time and undoubtedly many of the surplus senior registrars succeeded in obtaining higher appointments. Similar control procedures were applied in Scotland. As a result, the number of senior registrars in Great Britain had fallen to about 1,200 by the end of 1953.

62. In succeeding years the number of approved training posts has been increased in some expanding specialties and the present number (excluding those in dentistry) is:

England and Wales	1,051
Scotland	197
	1,248

SPECIALTY DISTRIBUTION

63. The specialty distribution of senior registrars in July, 1959, is shown in Table C of Appendix 3. It will be noted on the one hand that in some specialties the number of senior registrars is less than the number of training posts. Some of the specialties concerned are those in which unusual expansion has been taking place and senior registrars have often been obtaining consultant posts

(or in some cases senior hospital medical officer posts) without spending as long as four years in the grade. Mental health, radiology and anaesthetics are instances of these specialties. In a few specialties, notably chest medicine, where the requirements of the higher grades have unexpectedly declined, under guidance from the Health Departments hospital boards are deliberately refraining from appointing senior registrars to all of the posts nominally classified as training posts.

64. On the other hand the number of senior registrars in some specialties markedly exceeds the number of training posts. This has been so for general medicine, general surgery and obstetrics and gynaecology ever since the training plan was introduced; and indeed in these and some other specialties the position is worse than the figures suggest; for some of the training posts continue to be held by senior registrars wbo have completed their training. The excess in thoracic surgery, though small numerically, is relatively the most acute. Though a large surplus is shown for pathology, the position in the case of this specialty is complicated by the inclusion of a large number of doctors (44) not directly employed by hospital authorities. These doctors are employed in medical teaching and research and bold honorary appointments as senior registrars. But for their inclusion, the number of senior registrars in pathology would be closely in line with the number of training posts. The specialty indeed is one in which senior registrars have commonly proceeded to consultant or senior hospital medical officer appointments in less than four years. Apart, however, from this case, an excess of senior registrars over the number of training posts connotes an excess of supply over the immediately prospective demand.

AGE DISTRIBUTION

65. A similar situation is disclosed by the age distribution of the senior registrars in the various specialties, which is given for 1st July, 1958, for England and Wales in Table D(i) of Appendix 3. The proportion of senior registrars under the age of 35 in July, 1958, in each of the specialty groups shown in that table was as follows:

	Percentage of senior registrars in the specialty group who were under the age of 35
Medical specialties	44
Surgical specialties	33
Obstetrics and Gynaecology	39
Mental Illness and Mental Deficiency... ...	53
Radiology and Radiotherapy	61
Pathology	54
Anaesthetics	79

There are two possible explanations of these disparities. Doctors may have been reaching the senior registrar grade later in the medical and surgical specialties and in obstetrics and gynaecology than in the other specialties, or they may not have proceeded to higher appointments so quickly. No doubt both factors have operated. The age distribution in Scotland at the end of June, 1960, is shown in Table D(ii).

66. As already noted the Spens Committee contemplated that senior registrar appointments would normally be held at the ages of 28, 29 and 30. Even allowing for the fact that the original recognised normal period of tenure was later lengthened from three years to four, the structure up to this level has certainly not worked in the matter of age progression as the Spens Committee assumed it would. The average age of senior registrars in England and Wales was 35½ at 1st July, 1958, the latest date for which this information is available. Though the hospital service of many has been broken by two years' National Service, this does not bridge the difference.

CRITICISMS OF THE PRESENT POSITION

67. On this grade, as on others, assertions have been made in evidence that some members, although nominally in training to undertake consultant work, are in fact performing work of this kind as though they were already consultants. This evidence must be tempered by the consideration that the undertaking of work of the nature of that usually performed by a consultant is a vital part of the training process. What is wrong is that members of this grade, or of any other grade below the consultant grade, should be expected or permitted, tacitly or otherwise, to undertake consultant responsibility as a matter of routine. Temporary delegation of consultant duties is permissible only when there is available a consultant to whom the doctor performing the delegated duties can turn for advice, e.g. when a consultant is on leave there must be another consultant available to whom reference can be made.

68. Some comment is called for on the criticism levelled against the present structure that in most non-teaching hospitals there is a gap between the consultant and the registrar (or, sometimes, the senior house officer) which is filled in teaching hospitals by the senior registrar and needs to be filled just as much in the non-teaching hospitals. It is a fact that relatively few non-teaching hospitals have senior registrar posts and still fewer, if any, have such posts in each of the specialties practised at them. The criticism, however, discloses a misunderstanding about the senior registrar grade. Implicit in it is an impression that there is a class of medical work which may be called "senior registrar" work. This impression is incorrect. If there were such a class of work senior registrars would need to be employed as such to do it. In other words the grade would need to be a service grade in which the numbers required would be determined by the amount of "senior registrar" work instead of a training grade in which the numbers should properly depend on expected vacancies in the higher grades. A senior registrar is a registrar who having shown the potentialities of a consultant or senior hospital medical officer has been selected to undergo further training at a higher level and with increasing responsibility to fit him to compete for an appointment in one or other of these grades according to his specialty. The registrar is doing the same kind of work at a lower level of responsibility. Quite apart from the fact that the number of trainees should be related to anticipated vacancies, the facilities required for training for the highest posts in the service are not to be found at all hospitals. Other criticisms made are that:

(1) in some specialties the number of senior registrars has exceeded the number of vacancies available to them with the result that there are a

number of fully trained senior registrars ripe for higher appointments who are unable to secure them (a criticism which links with the comments made above on the specialty and age distribution);

(2) the difficulty produced by the excess of senior registrars is aggravated because in the competition for vacancies in the higher grades candidates who trained in teaching hospitals are preferred to those who trained in non-teaching hospitals.

THE FUTURE OF THE GRADE

69. The needs here are undisputed and imperative. They are (i) to select from among the aspirants to careers as consultants those most likely to become fitted for consultant posts; and (ii) to provide special training to fit them to discharge the full range of consultant responsibilities. Accordingly we recommend that the senior registrar grade should be retained, the posts in it being regarded as training posts primarily as hitherto. We find no need to suggest any change in the work and responsibility which a senior registrar should properly undertake. Though some consultant work must be undertaken in the latter part of training, such work should be done under consultant supervision and should not be performed independently, as a routine, as is often happening now.

PERIOD OF TRAINING

70. At present the Terms and Conditions of Service of Hospital Medical Staff envisage that a senior registrar post will normally be held for four years. This should continue to be regarded as the desirable normal duration of training and the number of training posts provided should be determined accordingly. Four years should not, however, be applied either as a rigid minimum or maximum. A senior registrar will have been fitting himself for his specialty and undergoing training before he attains the senior registrar grade and regard should be had to the total length and type of training since full registration when a decision is being reached whether he is ready for a consultant appointment.

CONTROL OF NUMBERS

71. The number of training posts required should continue to be reviewed and determined annually by the Health Departments, in consultation with representatives of the profession, including the Royal Colleges and the Royal Scottish Corporations, and with the specialty associations where appropriate, with a view to relating it to demand as closely as is practicable. It should be done by reference to the needs of Great Britain as a whole and there will accordingly need to be close liaison between the two Departments. Factors which should be taken into account in determining how many there should be are:

(i) the number of vacancies for consultants likely to arise in the years immediately ahead owing to retirements, deaths and expansion;

(ii) the number of doctors employed in the Hospital Service other than as senior registrars who should be taken into account together with senior registrars as probable competitors for consultant posts;

(iii) the number of clinical teachers and research workers at senior registrar level who should be taken into account as probable competitors for consultant posts, particulars of such clinical teachers and research workers with universities being supplied by the universities; the universities should be prepared to give the best estimate they can of the number of their medical staff, including the staff of pathological departments, whose next appointment is likely to be that of a consultant whether or not combined with a university post;

(iv) the need for senior registrars from this country to fill consultant posts overseas;

(v) wastage during training.

SELECTION AND REVIEW OF SENIOR REGISTRARS

72. However much care is taken in estimating the number of senior registrar posts required on the above basis there is bound to be a margin of error. This makes it all the more important that the strictest standards should be applied in selecting practitioners for entry to the grade and in reviewing them after entry. We recommend that the appointments committees for selecting new senior registrars whether for teaching or non-teaching hospitals should include representatives from both classes of hospital.

73. A report should be made on each new senior registrar one year after the start of his appointment with a view to a firm decision being taken by the time he has been in the grade for eighteen months whether he is suitable for retention, so that the decision may become effective at the end of his second year of training and the doctor be given proper time if necessary to obtain other work. A strict standard of reporting and reviewing should be applied at this stage. Where the decision reached is that the senior registrar appointment should be brought to an end, it will be open to the doctor who desires to remain in the Hospital Service to seek another appointment in the registrar grades—as he might well do if the consultant or consultants with whom he had been associated felt that he would do better in another specialty and he decided to try this specialty—or to apply for an appointment of unlimited tenure in his present specialty in the new grade which we recommend in paragraphs 122—132, or of course outside the Hospital Service.

SUBSEQUENT ACTION

74. With these measures few if any of those who are retained in the grade for the full period of training should fail to obtain consultant vacancies though success may not always come immediately. If a senior registrar fails to obtain a consultant post within a reasonable time of completing the normal term in the grade, we consider that he should be retained in the Hospital Service, if he wishes to stay, and if necessary be provided with a permanent appointment. At this stage he may well be in the middle thirties or even older and the termination of the hospital employment at this age of a doctor of such high qualifications and skill as are possessed by a fully trained senior registrar would be indefensible. What we recommend should happen in such a case is that when he has been a senior registrar for five years his case should be reviewed and one of the following courses taken if he desires to be retained in the Hospital Service:

(i) if the conclusion is reached that he should be retained in his present post for a further period while he continues to compete for a consultant appointment, his appointment should be continued on a year to year basis;

(ii) retraining in another specialty might be suggested if he is considered to have the potentialities of a consultant in this other specialty; or

(iii) an appointment should be found for him, without competition, in the new grade which we recommend in paragraphs 122—132.

In dealing with such a case the undesirability of having training posts in teaching hospitals blocked indefinitely to new entrants to the senior registrar grade should be kept closely in mind.

ROTATION BETWEEN TEACHING HOSPITALS AND NON-TEACHING HOSPITALS

75. There seems no doubt that senior registrars trained in teaching hospitals have had an advantage in the competition for consultant posts over those trained entirely in non-teaching hospitals. We therefore think that either all senior registrars should be trained in teaching hospitals or all senior registrars should be trained partly in teaching hospitals and partly in non-teaching hospitals. We favour the latter course as the customary one. We recognise that it may not be possible for it to be followed in all specialties and in all situations. Particular non-teaching hospitals should be designated to take part in the training of senior registrars and their designation for this purpose should be reviewed from time to time. There should be no difficulty in finding sufficient training places for rotational training. The requisite number in each specialty should be specified at the various teaching and designated non-teaching hospitals.

76. Some progress has already been made in developing rotational schemes of training of this kind. They should be developed to the utmost. The scheme in which training starts and finishes at a teaching hospital is frequently to be recommended but conditions vary and sometimes may call for a different pattern of rotation between the teaching hospital and the non-teaching hospital. The rotation arrangements to be followed should be made clear to the senior registrar on appointment and embodied in his agreement.

77. We have received much evidence that sometimes the development of schemes of rotational training has been handicapped by lack of suitable housing for a senior registrar moving from the one hospital in the scheme to the other, or by reason of the senior registrar being faced with greater expense, e.g. on travelling, than would fall upon him if the whole period of training were spent at one hospital. To help to secure the fullest extension of these rotational schemes it may well be found necessary for the hospital authorities of both teaching and non-teaching hospitals to see that suitable accommodation is available or to assist in other ways, e.g. by removal grants.

ORGANISATION AND SUPERVISION OF TRAINING ARRANGEMENTS

78. In carrying out the foregoing recommendations two factors are involved (i) the pattern of training and the designation of non-teaching hospitals, or posts in non-teaching hospitals, and (ii) the organisation and general supervision of training arrangements.

79. With regard to (i), the content of training in the specialties is a professional question primarily for the Royal Colleges, the Royal Scottish Corporations and the universities, but the pattern includes the provision of suitable opportunities for acquiring experience under supervision and in the selection of suitable posts for this training the Ministry of Health or the Department of Health for Scotland is also concerned.

80. *Joint advisory regional committees on senior registrars.* With regard to (ii), schemes for rotation demand integration of the training arrangements between the teaching and non-teaching hospitals concerned. These hospitals will, moreover, have a direct interest in the way in which a new senior registrar is shaping and in the provision to be made for what should be the rare case of the senior registrar who fails to obtain a consultant post. We consider that the necessary link between the teaching and non-teaching hospitals may best be maintained through committees established by the responsible hospital authorities—the regional hospital boards and the boards of governors jointly in England and Wales and the regional hospital boards in Scotland. Committees of this kind already exist in some regions. Wherever possible a single committee should cover the whole of a hospital region. The metropolitan regions in England, however, present a special case and in some or all of these regions it may be necessary to have more than one committee. The functions of the joint advisory committees should include:

(*a*) The oversight of the training arrangements in the region and the duty of advising on the development and organisation of rotational training schemes.

(*b*) The receiving of reports on all senior registrars at the end of their first year of service in the grade and advising whether the appointment should be continued.

(*c*) Advising on which course of the three outlined in paragraph 74 should be taken in the case of a senior registrar who has not obtained a consultant appointment by the end of his fifth year in the grade.

81. The committee should consist entirely of medical members. Its size should be settled between the regional hospital board and the board of governors in England and Wales and by the regional hospital board in Scotland and the important interest of the non-teaching hospitals as well as that of the teaching hospitals in the training of senior registrars should be reflected by aiming at equal membership between the two classes of hospital. The university of the region should be directly represented.

82. When the committee is called upon to advise upon a senior registrar who has been the subject of an adverse report they would no doubt usually wish to have the help of a consultant in the specialty in question and they should be free to co-opt a consultant for this purpose if the specialty is not represented among the standing members. It is very important that action should be taken promptly in such cases.

83. We wish to emphasise the importance of the best advice on prospects in the various specialties and other branches of medicine being available to senior registrars who prove not to be likely to obtain consultant appointments in the

specialty in which they have been training and also to registrars when they have to come to a decision whether to seek a senior registrar post or to turn to another branch of the profession for their career. We believe that the advisory committees could play a useful part in this matter, perhaps not so much by undertaking to give advice themselves as by acting as a regional clearing house for information about prospects.

VII. Needs requiring to be met by Doctors other than Consultants and Senior Registrars.

REGISTRARS AND HOUSEMEN

84. In the present structure the registrars—by which we mean in this context the basic grade registrars as distinct from the senior registrars—are intended primarily to carry out routine work under supervision by consultants. The complexity of the work entrusted to them by their consultants naturally depends upon the view taken by the consultants of the competence of the individual registrars but this work normally includes a wide range of routine procedures including, in surgical specialties, some of the simpler operative work without immediate personal supervision. To the registrar falls the immediate supervision of the housemen. Though some registrars—indeed a high proportion in obstetrics—are resident, the grade is not inherently a resident grade, as the house officer grade is, in the sense that its members are normally under an obligation to be always at hand day and night, subject to an off-duty rota.

85. The house officer, whether provisionally registered or fully registered is the first doctor to be called in in case of need and it is his duty to see inpatients daily. He assists the consultant and his own immediate senior as required, e.g. by performing the simpler routine medical tasks in ward or outpatient department and keeping case notes. Any surgical operations performed should be only of the simpler kind and should normally be done under the direct supervision of a registrar or consultant.

86. The senior house officer is often employed where a houseman of longer experience is required than is normally to be found in the basic house officer grade. Such a need may, for instance, arise in the highly specialised divisions of medicine and surgery. Sometimes, however, the duties of a senior house officer are more akin to those of a registrar than to those of a true houseman.

87. The figures given in paragraph 18 make plain the vital importance of the registrars and housemen in the staffing of the hospitals. In 1959 the doctors working in these grades represented just over 40 per cent of the hospitals' medical staff. Though over recent years the number of house officers in the basic grade has shown little change—which is not surprising since the number depends mainly on the annual output of graduates from the medical schools—the registrars and senior house officers have progressively become a bigger element in staffing. This fact is largely due to the evolution of new techniques leading to a far greater need than in the past for consultants to have assistance of the kind available from registrars and experienced housemen. Unquestionably doctors will continue to be needed to perform the functions we have described above. The need for them may well continue to grow.

88. We suggest that the names of the existing grades should remain as they are, i.e. registrar, senior house officer, fully registered house officer and provisionally registered house officer. We do so realising that there is a view that the name "registrar" is inappropriate to the registrar grade as now constituted, because hefore the National Health Service this name had come by tradition to mean a doctor in training to become a consultant, which it no longer does. Equally, however, it meant and still does a doctor engaged in the kind of work descrihed in paragraph 84, and for the last ten years or so this should have been the prime connotation of the name. This reason alone, quite apart from the difficulty of finding another name which would serve equally well, is sufficient in our view to warrant its retention. In so far as it may still in fact he taken today to mean essentially a doctor in training for the consultant grade, this is a survival of the past which should finally be effaced hy this report.

89. We have also considered carefully whether the grade of senior house officer should be retained as a separate grade in the structure since, as we have said, the duties of some posts in the grade are undoubtedly more those of a registrar than of a houseman while the duties of others are indubitahly those of a houseman. We have come to the conclusion that the balance of advantage lies in retaining the grade. Not only does it provide a means of giving suitable status to the housemen of greater experience required for some posts but it imports into the structure a desirable element of flexibility which should he preserved. Hospital authorities have found the provision enabling them to appoint senior house officers a useful one.

90. The question of the tenure of appointments in the grades is governed by the facts that:

(*a*) the new doctors graduating year hy year must have held two house posts, each of six months' duration, one being in medicine and one in surgery, or one in medicine or surgery and one in midwifery before they are entitled to be fully registered;

(*b*) some of the doctors completing these house posts will be aiming at a career in the Hospital Service and sufficient vacancies for fully registered house officers, senior house officers and registrars in the various specialties must be assured continuously so that those doctors have proper opportunities of gaining experience at these different levels and in different specialties and a proper flow of trained and experienced candidates for hospital posts at all levels is guaranteed; and

(*c*) it is of henefit to the health services in general and to medicine that new doctors who will be making their careers outside the Hospital Service should readily have opportunities of spending longer in hospital work than the minimum of twelve months required to entitle them to be fully registered.

Only by having these various grades composed of posts which will regularly become vacant can there he reasonable assurance that the necessary openings in the different grades and specialties will occur on the requisite scale. Accordingly our conclusion is that the posts in the house officer, senior house officer and registrar grades must he of limited tenure.

91. Though the tenure of the house posts for provisionally registered doctors will need to be the fixed term of six months, in the case of fully registered house officers, senior house officers and registrars, our conclusion that posts must be of limited tenure is not intended to mean that there should be strict rules about the time for which the posts should be held. The current Terms and Conditions of Service of Hospital Medical Staff envisage that registrar posts will normally be held for two years. In fact many registrar appointments do not last so long, while on the other hand many registrars spend more than two years in the grade, either in the same post or in a succession of posts. In the present circumstances attending the supply of junior staff, a matter on which we comment later, it would be unrealistic to seek to staff the senior house officer and registrar grades entirely by doctors who were prepared to take a post for at least one year or two years as the case may be. On the other band the arrangements about tenure should not prevent a doctor seeking, and where appropriate being given, an additional period of service beyond the period of the initial tenure. Accordingly, in our view the initial tenure of an appointment should be left to be settled between the employing authority and the individual doctor at the time the appointment is being made, subject to a maximum of one year for fully registered house officers and senior house officers, and two years for registrars.* At least twelve months' continuous service as a fully registered house officer or a senior house officer, or its equivalent, should normally be required of a candidate for a registrar appointment. We wish to stress that the maxima indicated are suggested as maxima for first appointments in the grade and that the appointments should in appropriate cases be renewable for periods up to the same maxima.

92. Having thus defined the tenure of the appointments in these limited tenure grades for the young doctors in training, we now turn to examine the basic assumptions of the present structure which we referred to in paragraph 24. Past experience shows that where consultants have been able to obtain the services as assistants of a sufficient number of young doctors in training, they have found this arrangement a very desirable one and have not seriously considered any other. Many of the leading hospitals, especially the teaching hospitals, have never known any other system. It involves inevitably fairly frequent changes in the junior staff and strains may arise where gaps occur between the end of one doctor's period of service and the beginning of that of his successor. But this drawback has been regarded as more than offset by the other advantages. This method of staffing, however, depends on the assumption that the supply of young doctors in training is and will remain in reasonably close relationship to the requirements of the Hospital Service for assistant posts of the kind which these doctors can fill. This assumption seemed so fundamental to our task that we took special steps to obtain accurate information that would enable us to test its validity.

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*Where it is planned at the outset that a doctor will hold a registrar appointment for two years, this will, of course, be subject to satisfactory service, and the continuance of the appointment for the second year will be subject to the employing board's approval.

93. The Deans of the Medical Schools in Great Britain have supplied the following information about the actual output of medical graduates in the calendar years 1955—59 and the anticipated output in the calendar years 1960—64:

Year	Graduates from Great Britain		Graduates from overseas
	Men	Women	
Actual Output			
1955	1,370	430	100
1956	1,484	395	102
1957	1,366	416	117
1958	1,313	362	142
1959	1,334	393	146
Anticipated Output			
1960	1,428	412	152
1961	1,275	411	158
1962	1,264	427	150
1963	1,281	438	193
1964	1,330	400	185
Totals	13,445	4,084	1,445

From information also supplied by the Deans it appears that with rare exceptions all new graduates from Great Britain enter the Hospital Service as provisionally registered house officers to get the requisite experience to entitle them to become fully registered. A proportion of the graduates from overseas will also do so. The figures show that a fall in the number of graduates from Great Britain is to be expected: the number is likely to average 1,700 per annum in 1961—64 as compared with 1,780 in 1955—60.

94. At some stage after becoming fully registered, the majority of doctors are likely to continue to leave the Hospital Service for medical work in other fields such as general practice, the armed forces, the civil service, the local government service, the universities and research, trade, commerce and industry, and some will leave the country to practise abroad. No reliable information being already

available about the numbers who stayed longer in hospital work than the year of provisional registration, or about how long these remained, the Health Departments and the hospital authorities made a census for us of the junior hospital staff employed on the 31st March, 1960, aimed at obtaining reliable data on these points. The particular grades within the census were those of registrar, junior hospital medical officer, senior house officer and house officer.

95. A full account of the census, together with tables analysing the information obtained is given in Appendix 4. We summarise here what seem to be the most significant results:

(i) At 31st March, 1960, 9,543 doctors were employed in these grades, 446 of them being employed as locums.

(ii) There were 873 vacancies, some of these, however, being filled for the time being by some of the 446 locums.

(iii) Of the 9,543 employed 3,236, or almost 34 per cent, qualified outside Great Britain and a larger number (3,628) were born outside Great Britain.

(iv) The graduate born in Great Britain is spending on the average a total of about three years in the junior grades in the Hospital Service, i.e. including his period as a provisionally registered doctor. (Some statistical assumptions which are explained in Appendix 4 have been used in the calculation of this period of service).

(v) The time spent in the junior grades by individual doctors, however, varies widely. At the time of the census the distribution of service of the 5,915 British doctors in these grades was as follows:

Period since first hospital appointment adjusted for National Service (see footnote to Table 2 of Appendix 4).	*Number of doctors*
Less than 1 year	1,533
1 year but less than 2	1,058
2 years „ „ 3	706
3 years „ „ 4	590
4 years „ „ 5	476
5 years „ „ 6	366
6 years „ „ 7	323
7 years „ „ 8	229
8 years „ „ 9	129
9 years „ „ 10	96
10 years and over	409
	5,915

(vi) It is calculated that 36 per cent of the British medical students stay in the Hospital Service for less than two years after entering it on graduating, that another 29 per cent stay less than three years and that only 35 per cent stay for three years or more. The manner in which these figures have been calculated is explained in paragraphs 9-11 of Appendix 4.

(vii) In some specialties the doctors from outside Great Britain form a majority of the junior staff other than the provisionally registered house officers. This is particularly marked in the surgical specialties. Of 2,189 doctors, other than provisionally registered doctors, in these specialties 1,298, or 59 per cent, are from overseas.

(viii) There is a difference in the extent to which the various regions are dependent upon doctors from overseas for junior medical staff. In the Leeds, Manchester, Newcastle and Sheffield Regions there are about as many overseas as British doctors in these grades. In other regions of England and in Wales the proportion is lower, though in no case less than one in three. Scotland is less dependent upon help from this source.

96. It will be seen that nearly half the total appointments in the Hospital Service are in these grades of registrar and helow where the appointments (other than in the junior hospital medical officer grade) are of limited tenure only hecause they were originally considered as primarily for training purposes. We referred earlier, in paragraph 24, to the assumption implicit in the present structure that what satisfies the needs of training would satisfy also the needs of the Service. Without the 3,628 doctors from overseas—a large number of whom are in this country for a short time only—there would ohviously he a hreakdown of staffing below the senior registrar grade. While we hope that many young doctors from overseas will continue to come to this country for postgraduate training, and that the Hospital Service will continue to provide suitahle places for them, we must not ignore the probability of some decline in that number as arrangements for postgraduate training are developed in their own countries. It seems undesirahle to assume that the Service can continue to depend so much on overseas doctors serving temporarily in this country.

97. There are other difficulties. The shortage inevitahly means that the availahle doctors must undertake more work than they would otherwise have to do. In our visits to general hospitals we have often found the junior staff to he overworked: this is specially so in non-teaching hospitals. Undue pressure of work must adversely affect the standard of service and restrict the scope for study. In this context we must again emphasize that though the doctors in the house and registrar grades are there to work as pairs of hands, they are also there as part of the process of preparing themselves for their ultimate careers for which study is still essential. The duties of those engaged in postgraduate study should allow time for it. In a statement with which we fully concur the Central Office Staff of the British Postgraduate Medical Federation presents the present position in the following way:

> "Before considering the staffing structure for hospitals, it is important to decide how much work should be required from house officers, registrars and consultants. It may be reasonable to expect house officers to be on duty 60–70 hours a week but graduates who have qualified for two or more years should have time to study, perhaps for postgraduate qualifications, and time to think critically about their cases. In many hospitals under Regional Hospital Boards, this is not the situation, and even registrars are so busily occupied with the care of patients that they have little or no time for study and reflection. Furthermore, they have to deal with emergencies and in many hospitals, because of their reluctance to request, or of the difficulty in obtaining, the help of consultants, they are tempted to deal with situations for which they lack knowledge and experience."

98. Moreover, according to our evidence, the number and quality of candidates for appointments are not always satisfactory. The inadequacy in quantity and quality is ascribed partly to the poor opportunities that have existed over the last few years as compared with the early years of the National Health Service of advancing to the senior registrar grade and thence to the consultant grade. Lack of security arising from the nominally restricted tenure of the posts is also mentioned as a causative factor. It is inevitable that a period of training for a consultant post will always be only a small fraction of the period of service in a consultant post. Unless the ratio of young doctors in these assistant grades were to be very drastically reduced, there could be no prospect of a much greater proportion of younger doctors going on to become consultants. There is no prospect of such a reduction, and it seems certain, therefore, that in the future, as in the past, only relatively few of the young doctors can look forward to the prospect of a consultant career.

99. These difficulties in junior staffing are not confined to Great Britain. It was shown in a recent Bulletin of the Hospital Council of Greater New York that for some time many of the hospitals in the United States had been unable to fill all their junior posts with graduates of American medical schools. About one-third of the doctors in these posts—as high as a half in New York City—were foreigners, most of whom were in the United States on visitors' visas. We understand that in Western Germany there is also a shortage of junior staff for the hospitals.

100. We recognise that past experience is not a decisive guide as to what may happen in the future. The ending of National Service in 1962 and the recent revision of the pay structure in accordance with the recommendations of the Royal Commission on Doctors' and Dentists' Remuneration might result in more young doctors spending longer in hospital work if these factors were to operate free from the influence of other factors operating in the opposite direction. It is unlikely that such other factors will be absent: the reduction in the number of new medical graduates from Great Britain which the figures in paragraph 93 show to be likely in the next four years may indeed represent one such factor. In view of the Willink Committee's* estimate that future requirements will be met if the medical schools in Great Britain produce about 1,655 British graduates on average over 1962-71, the average annual output in the coming years may in fact drop below the level of 1,700 indicated by the forecasts for 1961-64. The requirements of general practice inevitably react upon the position in the hospitals. If views on how many persons a general practitioner should be allowed to have on his list were to change, an important premise underlying the Willink Committee's estimate would become out of date and consequently the estimate itself might need to be revised. The output of the schools could not be varied for some years. An increase in the requirements of general practice before the number of doctors becoming fully registered was correspondingly increased might materially alter the situation with regard to junior hospital appointments. Notwithstanding these uncertainties, on one point there can be no doubt: the Hospital Service cannot hope to have an adequate and efficient

*Report of the Committee to Consider the Future Numbers of Medical Practitioners and the Appropriate Intake of Medical Students (1957).

staff of fully registered housemen and registrars unless reasonable prospects of a good career in some branch of medicine can he seen by the doctors who stay in the Service to work in these capacities. Otherwise the natural tendency is bound to he for the large number of doctors who will he making their careers outside the Hospital Service to leave for these careers at the first opportunity after becoming fully registered.

101. We helieve that these difficulties must be faced and that some changes are necessary if they are to be satisfactorily overcome. We consider first the possihilities of attracting many more young doctors to stay in the Hospital Service longer after hecoming fully registered. We then consider ways and means of enlisting the services of general practitioners on a larger scale so as to make the Hospital Service less dependent than it is now on the young doctors in training. As we explain later, these measures do not offer a complete solution, hut we helieve them to he integral parts of the solution.

THE QUESTION OF LONGER HOSPITAL SERVICE BY YOUNG DOCTORS GENERALLY

102. We do not suggest that steps should he taken to extend beyond the present twelve months the period of hospital service required to entitle a doctor to he fully registered, as a means of securing that all young doctors serve longer in hospital. We are sure that this aim should be achieved by persuasion not compulsion. If the young doctors can be hrought to realise that they will become better doctors and improve their professional prospects hy staying longer we believe that a growing numher will do so.

103. It is our firm view that a doctor who follows his year as a provisionally registered houseman by engaging in hospital work for a further period as a fully registered doctor will therehy usually hecome a better doctor and better fitted for whatever hranch of the profession his career may lie in. When a doctor becomes fully registered he has merely ohtained the basic qualifications, academic and practical, to work as a doctor in any branch of the profession. If he aims to make his suhsequent career in the Hospital Service he will usually need to take a higher qualification and to obtain at least seven years' further experience before he can hope to become a consultant. It is generally accepted that further experience after full registration is also desirahle hefore a doctor becomes a principal in general practice. We consider that ideally new entrants to general practice should have spent at least two years in the Hospital Service after becoming fully registered. If this became the regular career pattern of British graduates, a substantial contribution would be made towards the provision of adequate staff between the provisionally registered houseman and the registrar.

104. Representatives of the General Medical Services Committee with whom we have discussed the matter told us that all postgraduate training is helpful to the general practitioner. Especially useful is extra hospital experience in obstetrics and some other specialties such as paediatrics. A general hospital training in suhjects which are of use in general practice is better than concentration on one specialty. There is, however, a limit on the time a doctor proposing to enter general practice should spend in hospital work and the Committee's

representatives considered that in present circumstances he would not be wise to stay in preliminary hospital work for more than two to three years after becoming fully registered. After that it would become more difficult for him to secure a principalship; for after he had served as an assistant he would often find himself in competition with younger practitioners with just as much experience of general practice and these younger men might well be preferred for vacancies.

105. Though there is a widely held view amongst young doctors that a period of hospital service of that length after registration is regarded by those who select or appoint as a disadvantage rather than an advantage to a doctor seeking an entry to general practice, representatives of the general medical practitioners and the Chairmen of the Medical Practices Committees have not accepted that this is so. We see no reason why it should be, provided a doctor has not allowed himself to become over specialised. A doctor cannot, however, expect service as a registrar necessarily to be regarded as warranting an offer of an immediate partnership or appointment to a single-handed practice in preference to other applicants. He must usually be prepared to enter general practice, as so many other doctors will continue to have to do, by way of an assistantship.

106. We believe that the flexible arrangements which we have proposed for the tenure of posts in the house and registrar grades will facilitate the provision of a variety of experience which will be attractive to prospective general practitioners and invaluable to them in their future work; and which will thus encourage more to stay longer in hospital before going into general practice. Even where after full registration a house appointment is made for a year, which may often be more acceptable to a doctor than a shorter term, this does not mean that the holder need be confined to working for the whole time in one specialty : it is quite open to the employing authority and the doctor to arrange for him to spread his time over two, so that he may gain a more general experience.

107. We realise that such arrangements, whether they take the form of the doctor working concurrently in the chosen specialties or serving successive terms of, say, six months in them, may give rise to difficulties of administration. These difficulties must be accepted in the interests of providing the best experience and training for the prospective general practitioners. This should be no less a function of the hospitals than that of providing the best experience and training for the doctors who plan to make their careers in the Hospital Service. No doubt the appropriate bodies concerned with training for general practice will readily advise hospital authorities on the specialties in which experience and training is of most advantage.

108. The possibilities offered by arrangements under which prospective general practitioners split their time between hospital work and work in general practice as trainee assistants should not be overlooked. Several experimental schemes of this kind have been brought to our notice and, while they do not promise to make so marked a contribution to hospital staffing as do arrangements under which an extra year or two of wholetime service is rendered, they help to strengthen the link between hospital practice and general practice and are to be welcomed from the standpoint of the Hospital Service.

109. If our hope that two years' service in hospital after full registration will become customary is to be fulfilled, hospital authorities must see that a proper standard of accommodation is available for young doctors, this not necessarily being limited to those holding resident appointments. In the course of such a period of service many doctors will marry and unless suitable married accommodation is available to them, not necessarily at the hospital itself, for the rest of their temporary service some will undoubtedly be lost to the Hospital Service prematurely.

THE ROLE OF THE GENERAL PRACTITIONER IN HOSPITAL STAFFING

110. Further encouragement to prospective general practitioners to spend longer in hospital is likely to be provided if more openings are made available for suitably qualified general practitioners, by which we mean doctors who have served for, say, three years in the Hospital Service, including two years in the registrar grade or have had equivalent experience, to continue to work in hospital for part of their time in a responsible capacity. Many already do, as we have mentioned, but we are convinced that there is scope for more help to be obtained from this source. The kind of post which would best help in the junior staffing problem would require a daily visit of two or three hours to supervise the work of the house officers, to see newly admitted cases with them, to undertake or supervise the performance of technical procedures in the wards, and in certain cases to perform operations and undertake other responsible duties after consultation with the consultant in charge. It would be imperative that some of the visits coincided with visits from the consultant so that close contact could be maintained and the general practitioner assistants would be kept up-to-date with the requirements of hospital work. In some instances a general practitioner who has continued to work in the Hospital Service in such a capacity might later be chosen for a consultant post and pursue a career as a consultant concurrently with one as a general practitioner. In other cases, clinical assistantships at special clinics involving, say, a regular half-day a week are the kind of appointment that some general practitioners might well be able to undertake—as indeed is already being done to some extent. Though objection has been raised that general practitioners working in hospital would be seeing patients of other general practitioners, in our view this is an objection more in theory than in practice. It has not been seriously raised in places where general practitioners are already successfully working in hospitals.

111. The greater responsibility carried by general practitioners employed for supervising house officers as compared with those employed as clinical assistants at special clinics should be recognised by a difference in grading.

112. Though a single-handed practitioner will find it difficult to commit himself to hospital work of a kind that entails both regular visits and unpredictable calls, most general practice is now carried out in partnership (including group practice) and where this is so there should be possibilities of one or more of the partners being able to undertake a regular part-time commitment in the Hospital Service. We do not envisage that normally the hospital work should amount to more than five sessions a week at most. It is to be supposed, for example, that where a partnership practice is expanding it will pass through a phase when

the needs of the practice alone often do not require the wholetime services of an extra doctor. In such a case it will clearly be in the general interest if arrangements can be made for a doctor to be chosen for the vacancy who will devote part of his time to the general practice and part to hospital work. Though the opening in the Hospital Service must needs be in the same area as the general practice, with the present widespread shortage of hospital staff there must be cases in which it should be possible for the two vacancies to be linked. Where a hospital is suffering from a permanent shortage we suggest that the local general practitioners be given the opportunity to help by the responsible hospital authority's making known to the Executive Council and the Local Medical Committee, and through these bodies to the general practitioners in the area, that over the next two or three years the hospital will be able to absorb part-time service from suitably qualified general practitioners in specified kinds of work. Though a substantial increase in the work which general practitioners are doing in the Hospital Service cannot be expected immediately, this does not lessen the importance of providing the opportunities. Their contribution can only expand gradually as doctors with appropriate experience join their ranks from the Hospital Service but it may in time develop into an important one if the arrangements are such that the doctor and his partners do not suffer financially as a result of his spending part of his time in hospital work.

THE NEED FOR A GRADE OR GRADES OF UNLIMITED TENURE BELOW CONSULTANT LEVEL.

113. These measures would, we think, produce an improvement, but they will take time to develop and they do not offer an immediate or complete solution to the problem of providing the necessary staffing assistance to consultants. In this section of the report, therefore, we discuss the need for a new grade or grades in the Hospital Service of unlimited tenure below the consultant grade. The census has shown that a considerable number of doctors already remain in the Hospital Service in the existing grades between the provisionally registered house officer and the senior registrar for long periods or indefinitely. 1,215 of the 3,856 doctors born in Great Britain who are employed as fully registered house officers, senior house officers and registrars have completed five or more years in the Hospital Service on the assumptions detailed in Appendix 4, that is, they have already served a longer period than that after which a young doctor who could expect to become a consultant would be moving into the senior registrar grade. It can only be concluded that a significant number of doctors in these grades either do not desire or are unable to obtain more senior hospital posts or openings outside the Hospital Service. The existing structure makes no provision for this class in terms of permanent appointments carrying rates of remuneration determined on a career basis.

The present senior hospital medical officer grade.

114. The grade of senior hospital medical officer, which is a grade in which appointments are of unlimited tenure, has been the subject of controversy ever since its inception. As already explained the grade, though not recommended by the Spens Committee, was introduced to meet two needs, one of which would disappear in time and the other—the more important in the present context—of a more permanent kind, viz. the need considered to exist in some specialties

and some hospitals at least for doctors holding permanent appointments below the consultant grade to be available to perform work of limited scope, of lower responsibility and requiring narrower skills than that of consultants.

115. Some evidence has disclosed an impression that the size of the grade is increasing relatively to the consultant grade and that the grade is now existing irregularly. This impression is founded on a misapprehension. The latter part of it is disposed of by the terms of the agreement reproduced in Appendix 2. The former part is disposed of by the following comparative figures of the numbers of consultants and senior hospital medical officers in 1953 (the first year for which a reliable figure of the total number of senior hospital medical officers is available) and 1959:

GREAT BRITAIN

	1953	*1959*
Consultants	6,945	7,684
Senior hospital medical officers	2,508	2,420
Proportion of senior hospital medical officers to consultants	36 per cent.	31 per cent.

Thus the size of the grade has declined absolutely and relatively to the consultant grade.

116. Experience between specialties has varied and has naturally been influenced by the fact that the appointment of new senior hospital medical officers, though forbidden in some specialties since 1950, has continued to be permissible in others in the agreed circumstances. The specialty distribution of senior hospital medical officers in Great Britain in 1953 and 1958 (the latest year for which this information is available) is shown in Table E of Appendix 3.

117. Though in some specialties a large proportion of the senior hospital medical officers work wholetime in the Hospital Service, in others a large proportion work on a part-time basis, often for a small number of sessions. Many combine hospital work in this grade with general practice.

118. The age distribution of senior hospital medical officers is shown in Table F of Appendix 3. As with consultants, the age distribution varies between specialties. The decision of 1950 that new appointments in the senior hospital medical officer grade were not to be made in some specialties has been a special factor. Of the 197 senior hospital medical officers still employed in general surgery (which is one of those specialties) in 1957, 103 or 52 per cent were more than 53 years of age as compared with 30 per cent for all specialties.

Arguments advanced for and against the senior hospital medical officer grade or a similar one.

119. Though the gist of the evidence submitted to us on experience of the senior hospital medical officer grade is that it has fulfilled a useful function within the field in which its use is recognised, there is a cleavage of view on the question

whether the staffing structure should continue to provide for such a grade, whether called senior hospital medical officer or given another name and whether or not restricted to certain specialties or types of post. On the one hand, most of the professional bodies see objection to a sub-consultant grade—by which we mean a grade of unlimited tenure consisting of posts whose status would be near to that of consultant posts—while on the other hand most of the hospital authorities consider that such a grade is required in some form and some of them advocate the removal of the present limitations on the specialties and the types of posts in which new appointments of senior hospital medical officers may be made. Reasons adduced for a general grade of this kind may be summarised as follows:

(1) The day-to-day care of hospital patients often requires the services of senior and experienced doctors not necessarily of consultant grade for work which should not be left or delegated to the relatively inexperienced doctors in the junior grades.

(2) The grade would bridge the gap which exists in most non-teaching hospitals between the consultant and the registrar or (in some cases) senior house officers.

(3) The grade would provide a career for senior registrars and other doctors who do not eventually secure consultant posts; would thus provide a place in the hospital service for well qualified and experienced doctors capable of undertaking responsible work; and would thereby remove uncertainty about the future which is adversely affecting recruitment and morale.

(4) It would provide a means of meeting the need which exists where a unit has one consultant only for an experienced doctor to undertake some routine duties and to deputise for the consultant during off-duty periods and holidays.

(5) It would bring about a desirable measure of continuity among the staff below consultant rank which is often missing under the present structure due to changes constantly occurring among the junior staff.

Reasons adduced against such a grade are:

(1) As a clear line of demarcation could not be drawn in all specialties between the work of the consultant grade and that of a sub-consultant grade and the members of such a grade would often be qualified to do consultant work, in practice they would, as the years passed, increasingly be doing consultant work unsupervised or under only nominal supervision.

(2) The members of the grade would become frustrated and discontented because although many would be qualified to do consultant work there would be little prospect of their securing consultant vacancies.

(3) A stigma would attach to its members as being doctors who had failed to become consultants.

(4) It would be difficult to control the size of the grade.

(5) Difficult relationships would develop between its members and the consultants who would often be no better qualified academically and might be younger doctors with shorter professional experience.

Our views

121. We ourselves do not subscribe to either of these two lines of argument. Our approach is somewhat different. The senior hospital medical officer grade was an improvisation, as we have explained, and no part of the original Spens structure. Some members of it carry full clinical responsibility for their patients and as we have indicated our view is that in principle all patients should be in the charge of consultants. If it were to be continued otherwise than as a transitional measure for making provision for those already in it major changes would be required: it is too near to the consultant grade in status to be a satisfactory part of a permanent structure and we cannot therefore recommend its continuance as a permanent feature. From an appropriate date (which we express views on later) it should be closed to new appointments. Nevertheless we consider that the needs of the hospitals for assistants below consultant rank cannot be met without a grade in which the appointments are on a long-term basis. We deal with this question in the next section.

THE PROPOSED MEDICAL ASSISTANT GRADE

122. We have expressed the view in paragraph 73 that senior registrars who are not retained in the grade for full training should have an opportunity of competing for appointments in a grade of unlimited tenure; and in paragraph 74 we have taken the view that where a senior registrar does not proceed to a consultant appointment after undergoing a full training, he should be provided with employment of unlimited tenure, if necessary, so that he may remain in the Hospital Service if he so wishes with a sense of security. Accordingly a grade of unlimited tenure not above senior registrar level is required for these purposes. We have been forced to the conclusion that such a grade is required also to provide an opportunity for some registrars to remain in the Hospital Service on a satisfactory basis and in a position of security. Of the 3,266 registrars in post on 31st March, 1960, 992 have served for six or more years in the Hospital Service, given the assumptions detailed in Appendix 4, even after allowing for the two years' absence in the Forces of those who did National Service, and a large proportion, probably most, of these will now have been in the grade for more than three years. No fewer than 227 entered the Service ten or more years ago. 486 are aged 37 or more. Accordingly, though appointments in the grade are nominally for two years (and on terms related to appointments of this duration) it is evident that in fact a substantial number of doctors continue to be employed in registrar posts indefinitely and that there is need to retain their services. With the present numerical deficiency of assistants it is unthinkable that they should be denied an opportunity of obtaining suitable posts in which they may continue to work in the Hospital Service if they wish to do so, with security and on suitable terms. Moreover, those with long service would often experience difficulty now in obtaining entry to some other branch of medicine while in the Hospital Service their experience and skills are valuable. The existence of a large body of skilled doctors of this age and experience without any assurance that their services, though needed, will be retained, cannot fail to cause anxiety, to be bad for morale and detrimental to recruitment, qualitatively as well as quantitatively: it creates an atmosphere of uncertainty which may well militate against young doctors being persuaded to spend longer in hospital work before turning to other work. Security in their work will not tie

them to it against their wish: they will be free still to compete for advancement in the Hospital Service or to seek openings outside the Service, if they be so minded.

123. Overriding considerations are that:

(1) a satisfactory standard of consultant staffing is provided;

(2) the number of posts should be restricted so that there will continue to be a sufficient turnover of posts in the junior grades to allow all new entrants to the profession who desire to obtain additional hospital experience for one or two years after full registration to do so;

(3) the posts should be a supplement, not an alternative, to measures to encourage young doctors as a general rule to stay longer in hospital work after the year of provisional registration and to provide wider opportunities for general practitioners to assist in hospital work.

124. Our recommendations on consultants will, we believe, produce a satisfactory standard of consultant staffing. All proposals for the creation of posts in the new grade should be subject to the approval of the Minister of Health in England and Wales and of the Secretary of State in Scotland and in coming to a decision on proposals the responsible Minister should have available the advice of a body like the Advisory Committee on Consultant Establishments mentioned in paragraph 43 above. In advising, this body should have regard to the standard of consultant staffing and to the possibility of the local needs being met by a reasonable and attainable extension of the period new entrants to the profession spend in hospital work or by enlisting the help of local general practitioners.

125. Subject to these considerations we recommend that in future the staffing structure should include a grade, admission to which will normally be restricted to doctors who have held a registrar appointment for at least two years and have served in the Hospital Service for at least three years since full registration or have had equivalent experience (which will include senior registrars who have not proceeded to consultant appointments).

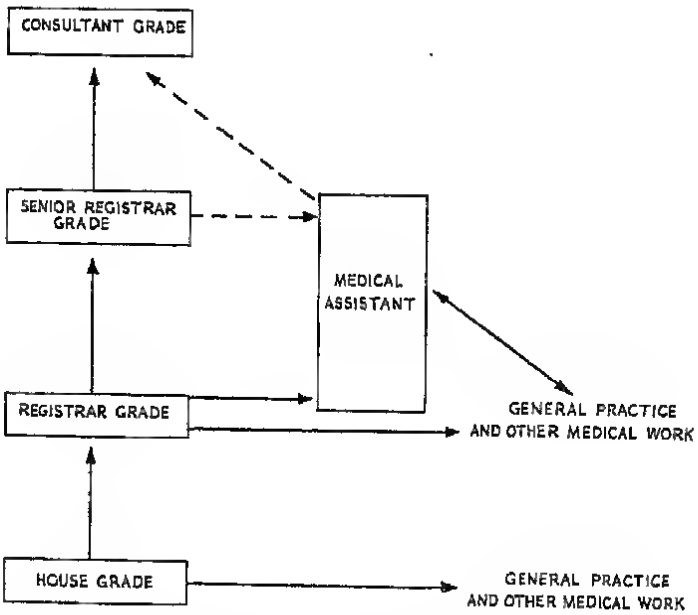
126. Appointments in the grade should not be of limited duration. They should be made by regional hospital boards and boards of governors in England and Wales and by regional hospital boards in Scotland. We take the view that the National Health Service (Appointment of Specialists) Regulations, 1950, should not apply to the making of appointments to the grade. Vacancies should, however, be advertised and filled by competition except where they are to be filled by senior registrars who have undergone a full period of training but have not proceeded to consultant appointments.

127. The grade should be clearly distinguishable from the consultant grade in responsibility, status and name. The work common to all specialties in which its members might properly engage is work such as is done by the registrar grade. All members should work as assistants to consultants and under their supervision, except any in ophthalmology who may be engaged solely on refraction. The position in this respect should be embodied in the doctor's contract.

128. General practitioners enlisted on a part-time basis to supervise housemen as we have recommended (paragraph 110) should hold part-time appointments in the grade, and there may well be circumstances in which a doctor holding an appointment in the grade would work in the local authority health services for part of his time.

129. The generic name of the grade should be Medical Assistant but in the specialties (other than general medicine in which Medical Assistant is appropriate also as a specific name) the particular appointments should be known as Assistant in Surgery, Assistant in Chest Medicine, etc. according to the specialty. They should not be called Assistant Physician or Assistant Surgeon since these names are used in some hospitals for appointments of consultant status.

130. Members of the grade should be recognised as being potential candidates for consultant appointments. The following diagram shows the place we visualise for the new grade in the staffing structure, the continuous connecting lines denoting the usual channels of advancement and the broken lines the less usual.



If some doctors after becoming medical assistants wish to leave hospital work for another branch of medicine there will, of course, be nothing to prevent them from doing so.

131. Though the settlement of a salary scale for the grade rests with others we cannot adequately indicate the status which we consider should attach to the grade without touching in a general way on pay. Constituted as we propose, the grade will consist of doctors with widely varying experience. On the one hand some will no doubt secure appointments to it after a minimum of two years' service as registrars and three years after full registration: on the other it will include in the first instance senior hospital medical officers and senior registrars who have not succeeded in obtaining consultant appointments and

other doctors of really long service and ripe experience in registrar work. We hope that part-time service from general practitioners who have been through registrar posts will become an important element in its composition. To cater for this wide range of experience a relatively long incremental scale seems to be indicated. Time-expired senior registrars might enter the scale at a point that took account of the salary they had been receiving in the senior registrar grade. For recruitment the scale must hold the promise of an ultimate reward sufficiently high to make the grade a career grade for those doctors who have to spend the remainder of their professional life in it and to attract into it suitably qualified general practitioners for part-time work.

132. The continuity of service and interest offered by the medical assistant grade should be a real advantage in some hospitals. Though we foresee a greater need for the grade in the non-teaching hospitals, particularly those not designated for the training of senior registrars, than in the teaching hospitals, we think that teaching hospitals may sometimes find a staffing need that can best be met by using the new grade. There may be a place for it in highly specialised departments where skilled assistants are required for long periods. In many hospitals there may be a place both for registrars and medical assistants, sometimes possibly in the same departments. Later we refer to special needs in particular specialties which we believe can be met through the medical assistant grade.

THE JUNIOR HOSPITAL MEDICAL OFFICER GRADE

133. As we have explained this grade was originally intended as a transitional grade for doctors transferred in 1948 to the hospital service in junior appointments of unlimited tenure. Its use as a grade in which appointments might be of limited duration is a more recent development. In our view it is too subordinate a grade for new appointments of unlimited tenure and we can discover no justification for a grade of limited tenure separate and distinct from the registrar and house grades. It appears to us that work at this level must be appropriate either to a registrar or a houseman if performed by a hospital doctor or to a clinical assistant working either on a regular or occasional basis if performed by a general practitioner. Accordingly the grade should be closed to new appointments so that it will disappear in time.

VIII. The Special Needs of Particular Specialties

134. The structure outlined above of consultants, senior registrars and medical assistants, registrars, senior house officers and provisionally registered and fully registered house officers, is intended to meet the needs of all specialties. After considering the evidence submitted to us by the various specialist bodies we find no need which cannot be met by that structure notwithstanding that the organisation in the individual specialties cannot follow a common pattern in every detail. The widespread distribution of consultants in the large specialties provides scope for a wider organisation of firms than in some others where consultants are few and far between. Though the introduction of the firm system everywhere in all specialties is not practicable, our point remains that there is scope for its adoption on a much bigger scale than now.

135. There are bound to be differences in detail in the more junior grades between specialties. Most provisionally registered house officers are necessarily employed in general medicine and general surgery. In some other specialties the general need for assistants in the junior grades is proportionately less than in general medicine and general surgery. In some there is little scope for doctors below the senior house officer grade. In physical medicine indeed there is little scope for doctors below the registrar grade.

136. In various specialties special needs exist for experienced assistance which can well be met in future by appointments in the medical assistant grade. Examples of this special need are as follows:

Paediatrics. To provide trained assistants in some areas where a paediatrician is working single-handed, a permanent grade is required. This grade should be staffed by doctors who have served for at least two years as paediatric registrars, and who hold part-time appointments not normally exceeding five sessions per week, the rest of their time being spent in general practice or in the local authority health services.

Geriatrics. In this specialty, where stay in hospital tends to be protracted calling for continuity of care, and where local contacts are important, e.g. with general practitioners, officers of the local health and welfare authorities, etc. skilled assistance is frequently required from doctors with long-term appointments. Junior posts in the specialty offer a useful training for future general practitioners who might be used later as clinical assistants or, where they have had the requisite registrar experience, as part-time medical assistants.

Venereology. Most of the work calls for consultant skills but there is need, in addition, for the medical assistant grade in which suitably experienced general practitioners should be able to play a useful part through part-time appointments.

Psychiatry. Modern psychiatric methods require a much larger proportion of the available medical time to be devoted to outpatient and day hospital work and the active treatment of inpatients. For this, the consultant-registrar type of staff organisation, preferably within a firm system, which may sometimes include medical assistants and—at the house level—senior house officers, is appropriate.

Physical Medicine. Senior registrars and registrars, who will generally be the only junior staff in the time-limited grades employed in the specialty, will normally be found only in a limited number of training centres. Experienced assistance is required elsewhere.

Ophthalmology. A long-term grade is required for doctors employed to undertake refraction only.

Anaesthetics. Whilst some of the everyday work can be undertaken by members of the time-limited grades under supervision, assistance is also required from doctors, including general practitioners, who have had registrar experience in the specialty and are employed on a long-term basis.

Pathology. In addition to senior house officers, registrars and senior registrars, a grade in which doctors experienced in the specialty might serve on a long-term basis as assistants to consultants is required.

Radiotherapy. Assistance is required for which doctors with registrar experience in the specialty should be employed on a long-term basis.

Casualty Work. The position in casualty departments calls for more comment. In this context we are thinking of casualties in the sense of injuries. In our experience, the medical staffing of casualty departments is the least satisfactory feature in the present hospital staffing system. Though in many hospital centres there is, in theory, consultant supervision of the casualty departments, and in a few larger centres consultants have been appointed with the specific responsibility for casualty departments, in most of those of which we have experience consultant supervision is insufficient and, in some, it is purely nominal. For the time being, in some sixty centres doctors of experience have been appointed within the senior hospital medical officer range of salary, and with the title of senior casualty officer, to casualty departments (see paragraph 12).

In our view the first principle in the staffing of casualty departments should be that one or more consultants should have a specified responsibility for casualty work, and a definite and sufficient part of their time allotted to its supervision. Much of the work is of a kind in which a policy for treatment can be defined reasonably closely and supervised by the senior staff concerned. The seniors would be available to assist with difficulties, and should have regular times of attendance at the casualty departments, though this should not become a substitute for ordinary consultative outpatient work. The practice of allotting beds to the casualty department may have a place where responsibility for those beds rests with consultants.

Junior staff in casualty departments, of whom there is a shortage at present, should be fully registered practitioners, preferably in their third or subsequent years after qualification. In the larger departments there is a place for senior house officers but this work is of such responsibility that registrars or doctors who have had registrar experience are to be preferred. Accordingly the medical assistant grade should help with the staffing problems of casualty departments, whether represented by the ordinary casualty department or a special accident centre. Where appointed, medical assistants should be fully embodied in the "team" and care taken to maintain their interest in the development of the service. We think that considerably greater use could be made of suitable general practitioners, as at the Birmingham General Hospital, and greater efforts should be made by all hospital authorities to obtain help of this nature.

IX. General Practitioners and Hospital Staffing

137. As noted in paragraph 13 it has always been recognised that a general practitioner who is qualified for a consultant or senior hospital medical officer appointment might hold a part-time appointment as such while continuing to carry on his general practice. There are current instances of doctors engaging in this way in both hospital practice and general practice. Though under our proposals the senior hospital medical officer grade will no longer be open to

new appointments it is our hope that general practitioners with the hospital experience required for the medical assistant grade will be given and will take every opportunity of participating in hospital work through part-time appointments in this grade (paragraphs 110 and 128). Equally with other members of the grade they will be free to compete for consultant appointments. There will be advantage if the reference to the medical assistant grade which will need to be incorporated in the Terms and Conditions of Service of Hospital Medical Staff makes specific reference to general practitioners with the necessary hospital experience as being doctors qualified to be appointed to it.

138. The Terms and Conditions of Service already contain specific provisions about:

(*a*) general practitioners working in general practitioner hospital units, whether at cottage hospitals or in wings of general hospitals and paid out of a staff fund;

(*b*) general practitioners employed as part-time medical officers at convalescent homes, general practitioner maternity hospitals or other types of hospitals and paid on a time basis;

(*c*) general practitioners undertaking occasional work in the Blood Transfusion Service and paid on a time basis.

139. We visualise that general practitioners will continue to be employed at cottage hospitals in which they maintain responsibility for their own cases with advice available from consultants visiting regularly. We favour the continuation of experiments in the provision of general practitioner wards in general hospitals. Such provision may relieve the consultants' beds of some cases, but we think it unlikely that it will make a major contribution to the staffing needs for the care of consultants' cases.

140. Provision will continue to be required for the part-time employment of general practitioners responsible for the general medical oversight of patients in convalescent homes.

141. In obstetrics and gynaecology there is room for suitably qualified general practitioners to take quite a special part in hospital work. Already many general practitioner obstetricians have the opportunity of caring in general practitioner maternity hospitals for normal obstetric cases amongst their patients. Their contribution to hospital staffing might well be extended by enlisting selected general practitioner obstetricians for part-time work, in the proposed medical assistant grade, in the clinical teams in other maternity units and at ante-natal and post-natal clinics.

142. As we have already mentioned we foresee a continued need for the part-time employment of general practitioners as clinical assistants in special clinics. Although the provision in the Terms and Conditions of Service about the employment of general practitioners as "part-time medical officers at convalescent homes, general practitioner maternity hospitals or other types of hospitals" has

been accepted as covering the employment of general practitioners in the capacity of clinical assistant we are surprised that express recognition of clinical assistants does not appear in the Terms and Conditions. So much importance is to be attached to the scope for general practitioner assistance being apparent and not having to be deduced that we consider that in this case also suitable reference to employment in this capacity should expressly be embodied in the Terms and Conditions of Service.

143. The provision for the employment of general practitioners for occasional work in the Blood Transfusion Service should also continue. Where their help is required in this service for regular work, part-time appointments may at present be made in any of the regular grades or as a clinical assistant as may be appropriate. This should continue but be extended to include also the proposed medical assistant grade.

X. Review and Reorganisation of Staffing

144. We recommend that the regional hospital boards and boards of governors should institute a review of the medical staffing of their hospitals in the light of the principles set out in this report and of the changes in structure recommended, and that on completion of the review they should submit a report on it to the responsible Minister together with proposals for:

(*a*) such additional consultant appointments as are considered to be required immediately having regard to present demands upon the Service and the accommodation and other facilities currently available;

(*b*) their requirements by way of posts in the medical assistant grade, taking due account of the possibilities of securing longer service in the junior grades from young doctors before they leave for other spheres of work, and of enlisting the part-time service of suitably qualified general practitioners in the new grade.

145. In making this review the boards (i) should have adequate professional advice either from individual consultant advisers or from advisory committees or from both; and (ii) should bring their consultant staffs into consultation from the outset.

146. In framing their proposals regional hospital boards and boards of governors should carefully examine the possibilities of the firm system being more widely adopted. The development and working of the system in a hospital group can in our view best be dealt with by the medical staff of the group. The group's staff might consider whether action can best be taken through its normal committees, through the senior consultant, or through a consultant designated to work in the capacity of a medical administrator for part of his time on the lines recommended by the Bradbeer Committee*.

*Central Health Services Council: Report of the Committee on the Internal Administration of Hospitals, paragraphs 71–78.

147. Similarly boards should closely examine the possibilities of securing more effective use of consultant time by reorganisation of consultant service to reduce travelling and other non-effective time, though not to the exclusion of valuable pastoral visits. Proposals for modification of contract should be made where this is justified. In such a case the matter should be discussed with the consultant at the earliest opportunity and a solution sought by agreement.

148. The reports with which the proposals under paragraph 144 are submitted should include statements of the action taken or proposed on the development of the firm system, the reorganisation of consultant service, and in the case of regional hospital boards the development of arrangements for senior registrars to rotate between teaching hospitals and the boards' hospitals and for establishing joint advisory regional committees on senior registrars as recommended. The making of the review and the preparation of the reports in the manner and on the matters indicated will be a considerable task. Nevertheless we hope that it may be found to be one that can be done thoroughly, as is imperative, within a reasonable time. The work of the responsible hospital boards in reviewing and reporting and of the central departments in considering the reports may be facilitated if the boards prepare and submit their reports sectionally, i.e. either for individual specialties or groups of specialties, or in the case of regional boards for parts of their regions.

149. We recommend that the responsible Minister should seek advice on the proposals for additional consultant appointments and for the establishment of medical assistant posts from a professional committee consisting of members appointed by him and by the Joint Consultants Committee.

150. In the review of staffing, consideration will, of course, need to be given to the future of the posts at present occupied by the senior hospital medical officers who, as mentioned in paragraph 45, are receiving a special allowance of £550 per annum in addition to their ordinary salary on the ground that for all or most of their time they are undertaking work which after their tenure of the posts will be performed by consultants. Where a senior hospital medical officer holding such a special allowance is occupying a post which is approved as a consultant post following the review to be conducted by regional hospital boards and boards of governors, we consider it only just that he should be entitled to have the question whether his professional status in the post is properly that of consultant, not senior hospital medical officer, reviewed by his employing board advised by a professional committee. Failing arrangements to this end being made, the only way in which a senior hospital medical officer in this position could secure that the question of his upgrading to consultant is reveiwed would be by resigning the appointment and entering the competition for it when it is advertised as a consultant post. He could have no guarantee of succeeding in the competition. We do not consider that doctors of senior status, who will often also be senior in age, can reasonably be expected to take the professional and financial risks involved in such a course. If the recommendation made in paragraph 151 is adopted there would be no other senior hospital medical officer appointments for which they might apply if they failed in the competition. The criteria to be applied in such reviews of personal grading should be the same as

would apply to candidates for new consultant posts under open competition and similar machinery to that applicable to the selection of new consultants should be used by boards for making the reviews.

151. After the introduction of the medical assistant grade no more senior hospital medical officers or senior casualty officers should be appointed and no increases should be made in the sessions of the holders of part-time appointments in either of these capacities.

152. Finally, we wish to emphasize how important it is that information should be regularly available to enable the position in the various grades to be reviewed not only by reference to the numbers in the grades but also by reference to the age distribution in the grades, the period which new doctors are spending in the grades of limited tenure, and the geographical distribution of vacancies. The Health Departments regularly collect certain information besides numbers for the senior grades and as we have mentioned they were good enough specially to collect particulars for us about the members of the registrar, junior hospital medical officer and the house grades. It was invaluable. The regular publication of information on such matters would do much to help the young doctor—and those called upon to advise him—to decide upon his future career. In view of the extent to which the Hospital Service is dependent upon young doctors from overseas whose stay here is temporary and the uncertainty whether this help will continue to be available on the present scale, we consider it is essential that information about the number of these helpers from overseas should be collected every year so that if and when the number falls this may be detected without undue delay and such steps as may be necessary taken to make the loss good. For similar reasons we consider that the Health Departments should regularly receive information about the actual output of graduates from the medical schools and estimates of the output over a series of future years having regard to the fact that any action that might be required from time to time to expand or curb the output would not have any effect upon the output for the best part of ten years. Further, in view of the real help which we believe is obtainable from general practitioners, information should be collected to show the extent to which general practitioner help is being obtained.

XI. Summary of Main Conclusions and Recommendations

General

(1) The staffing structure must be based upon consultants as being the only doctors in the Hospital Service who should take full personal responsibility for patients and the medical work required for them (paragraphs 28, 30 and 47).

(2) The structure below the consultant grade must provide for:

(i) doctors required to assist consultants

(ii) doctors needing postgraduate experience and training in hospital as a preparation to their professional career (paragraph 29).

(3) In order that the hospitals' obligations in providing postgraduate experience and training may be fulfilled many of the assistants' posts must be of limited tenure (paragraph 31).

(4) The structure must have regard to the facts that:

(i) there will be some doctors who do not succeed in obtaining consultant appointments for whose future the Hospital Service must provide;

(ii) general practice depends upon the Hospital Service for its new entrants;

(iii) suitably qualified general practitioners should take part in hospital work (paragraphs 32 and 33).

Consultants

(5) A consultant is a doctor chosen by reason of his ability, qualifications, training and experience, to take full personal responsibility for the investigation and/or treatment of patients without supervision in professional matters (paragraph 40).

(6) More consultants are needed (paragraph 41).

(7) Consultant responsibility is being excessively or inappropriately delegated and is being borne by senior hospital medical officers, senior registrars and members of junior grades (paragraphs 41 and 45).

(8) This situation is due to a variety of factors, many of which are listed (paragraph 42).

(9) A consultant's responsibility to his patients applies to them all continuously (paragraph 47).

(10) The extent to which duties and responsibilities are delegated to doctors below consultant rank, who should act as assistants to the consultants, will vary between specialties and according to the seniority and experience of the assistants (paragraph 47).

(11) The consultant's overall and personal responsibility for his patients continues notwithstanding delegation (paragraph 47).

(12) A consultant should devote sufficient time to his hospital to enable that responsibility to be discharged: in hospitals largely concerned with the treatment of acute illness the aim should be for every inpatient to be seen by the responsible consultant two or three times a week at least (paragraph 47).

(13) The existing practice of allowing a consultant to choose between a contract for wholetime service or one for maximum part-time service, subject to the needs of the Hospital Service should continue (paragraph 47).

(14) When part-time appointments for a small amount of service have to be filled they should, where practicable, be absorbed into the duties of existing staff or grouped together (paragraph 47).

(15) A consultant's duties should be precisely stated in his contract (paragraph 47).

(16) Consultants' services should be more extensively organised on the firm system (paragraphs 48—56).

(17) In the view of the Working Party's clinician members, as a rough guide in acute units in general medicine and general surgery a firm of two wholetime or maximum part-time consultants working at a non-teaching hospital and assisted

by one registrar and two housemen might be expected to be able to take responsibility for 60—80 inpatients with the associated outpatient and emergency duties. The number may, however, vary widely with local conditions and the type of work (paragraph 57).

Senior Registrars

(18) The senior registrar grade should be retained primarily as a training grade (paragraph 69).

(19) Four years should continue to be regarded as the desirable normal period of training but should not be applied as a rigid minimum or maximum (paragraph 70).

(20) The number of training posts required should be reviewed annually by reference to the needs of Great Britain as a whole taking account of (a) prospective consultant vacancies (b) the number of doctors likely to be in the field of competition for them (paragraph 71).

(21) All appointments committees should include representatives both from teaching hospitals and from non-teaching hospitals (paragraph 72).

(22) A report on a senior registrar's suitability for continued training should be made after his first year in the grade and a firm decision taken within six months thereafter whether he is suitable for retention in the grade (paragraph 73).

(23) Permanent employment should be assured to a fully trained senior registrar in an appointment in another grade if he does not obtain a consultant post (paragraph 74).

(24) Schemes for rotation between a teaching hospital and a non-teaching hospital during the normal four-year training period should be further developed, particular non-teaching hospitals being designated for senior registrar training and their designation being periodically reviewed (paragraphs 75—76).

(25) The fullest extension of rotational schemes may sometimes depend on suitable accommodation or removal grants being available for the senior registrars (paragraph 77).

(26) Joint advisory regional committees should be established in each region of representatives of the regional hospital board, the board(s) of governors and the university, to organise and supervise rotational schemes and to advise on the suitability of individual senior registrars for retention in the grade: the committees might also act as a regional centre for information about prospects (paragraphs 78—83).

Registrars and Housemen

(27) The registrar, senior house officer, house officer (fully registered) and house officer (provisionally registered) grades need to be retained and should continue under their present names (paragraphs 84—89).

(28) Appointments as registrar, senior house officer and house officer (fully registered) should be for a limited period agreed between the employing authority and the doctor within a maximum of one year for the house officers and senior house officers and two years for registrars, but an agreed extension of these periods should be permissible (paragraphs 90 and 91).

(29) A candidate for a registrar appointment should normally be required to have had twelve months' continuous service as a houseman after full registration, or equivalent service (paragraph 91).

(30) There is a shortage of staff in the junior grades and but for the service available from doctors from overseas, mostly here for postgraduate training and experience, the staff situation in these grades would be critical (paragraphs 93—97).

(31) Quality also is sometimes deficient (paragraph 98).

(32) The Hospital Service will not secure an adequate and efficient staff of fully registered housemen and registrars unless reasonable prospects of a good career in some branch of medicine are assured to the doctors who serve in these capacities (paragraph 100).

(33) Integral parts of any solution of the junior staffing problem are (a) longer hospital service by young doctors (b) more help by general practitioners, though time will be needed for these sources of help to be developed (paragraphs 101—112).

(34) A doctor who continues to work in hospital after becoming fully registered becomes a better doctor: ideally new entrants to general practice should have spent at least two years in hospital work after becoming fully registered and if this became the regular pattern for British graduates a substantial contribution would be made to junior hospital staffing (paragraphs 103—107).

(35) The availability of satisfactory accommodation for married as well as unmarried doctors and not necessarily limited to doctors holding resident appointments will have an important bearing on the readiness of doctors to stay longer in the junior hospital grades (paragraph 109).

Senior Hospital Medical Officers

(36) The senior hospital medical officer grade should not continue to be recognised as part of the permanent structure (paragraph 121).

Medical Assistant Grade

(37) A need exists for a grade of unlimited tenure below consultant rank, and clearly distinguishable from the consultant grade. It should consist of doctors who will work as assistants and should be open to doctors with two or more years' service as registrars, who have worked in hospital for three years or more since full registration (paragraphs 122—125, 132 and 136).

(38) Overriding considerations in the establishment of such a grade are that

(1) a satisfactory standard of consultant staffing is provided;

(2) the number of posts is controlled;

(3) the grade should supplement not replace measures to encourage young doctors to stay longer in hospital work before going into general practice etc. and to provide more scope for general practitioners to help in hospitals (paragraph 123).

(39) The new grade should be known as the Medical Assistant grade; the creation of posts in it should be subject to the approval of the responsible

Minister; appointments to it should be made by regional hospital boards and boards of governors in England and Wales and by regional hospital boards in Scotland; vacancies should be advertised and filled by competition (except where it is a matter of providing a post for a fully trained senior registrar who has not proceeded to a consultant appointment) but the National Health Service (Appointment of Specialists) Regulations should not apply; both wholetime and part-time appointments should be permissible; and members of the grade should be recognised as being potential candidates for consultant appointments (paragraphs 124—130).

(40) A relatively long incremental scale of pay would seem to be required (paragraph 131).

Junior Hospital Medical Officers

(41) The grade should be closed to new appointments (paragraph 133).

The Special Needs of Particular Specialties

(42) Special needs exist in some specialties for long-term appointments below consultant level: the medical assistant grade will provide a means of meeting these needs in future (paragraph 136).

General Practitioners and Hospital Staffing

(43) The employment of suitably experienced general practitioners in part-time hospital appointments as medical assistants in which they will make regular daily hospital visits for supervising house officers should be developed in addition to clinical assistantships at special clinics (paragraphs 110—112 and 128)

(44) Specific recognition should be given in the Terms and Conditions of Service of Hospital Medical Staff to the employment of general practitioners as part-time medical assistants and part-time clinical assistants (paragraphs 137 and 142).

Review and Reorganisation

(45) Hospital boards should, with consultant advice, institute a review of the medical staffing of their hospitals in the light of the principles set out by the Working Party and of the recommended changes in structure and submit a report to the responsible Minister together with proposals for such additional consultant appointments as may be found to be required and for posts in the medical assistant grade (paragraphs 144—145).

(46) The report should deal with the development of the firm system, the reorganisation of consultant service and the development of rotational schemes of training for senior registrars and the establishment of joint advisory regional committees on senior registrars (paragraphs 146—148).

(47) The responsible Minister should seek advice on the proposals for additional consultant appointments and for the establishment of medical assistant posts from a professional committee consisting of members appointed by him and by the Joint Consultants Committee (paragraph 149).

(48) Where a senior hospital medical officer receiving the special allowance of £550 per annum is occupying a post which is approved as a consultant post, following the review, he should be entitled to have his professional status in the post reviewed (paragraph 150).

(49) After the introduction of the medical assistant grade no more senior hospital medical officers or senior casualty officers should be appointed (paragraph 151).

(50) Information should regularly be obtained and published—

(i) about the size of the various grades and also on such matters as the age distribution in the various grades, the period young doctors are spending in the grades of limited tenure and the number of overseas doctors working temporarily in the Hospital Service;

(ii) the extent to which help from general practitioners is being enlisted;

(iii) the output of graduates from the medical schools (paragraph 152).

ROBERT PLATT (*Chairman*)
R. R. BOMFORD
JOHN BRUCE
J.D.S. CAMERON
ANDREW CLAYE
KENNETH COWAN
HAROLD C. EDWARDS
G.E. GODBER
NORMAN W. GRAHAM
T. ROWLAND HILL
A.S. MARRE
T. HOLMES SELLORS

N.C. Rowland
D.P. Stevenson

Joint Secretaries

December, 1960

Appendix 1.

List of Bodies and Persons from whom Evidence has been received

(The written evidence of the bodies marked * has been supplemented by oral evidence)

HOSPITAL AUTHORITIES, ETC.

Regional Hospital Boards

*Birmingham
Eastern (Scotland)
Leeds
Liverpool
Manchester
North East Metropolitan
North-Eastern (Scotland)
*North West Metropolitan
Oxford
Sheffield
South Eastern (Scotland)
South Western
South West Metropolitan
*Welsh
Western (Scotland)

Associations

*Association of Hospital Management Committees
Association of Scottish Hospital Boards of Management
Executive Councils Association (England)
*Teaching Hospitals Association

Others

Board of Management for the Angus Hospitals
*Northern Ireland Hospitals Authority
*Senior Administrative Medical Officers, England and Wales

PROFESSIONAL BODIES

*Anaesthetists Group of the British Medical Association
*Association of Anaesthetists
*Association of Clinical Pathologists
*British Association of Dermatology
*British Association of Otolaryngologists
*British Association of Paediatric Surgeons
British Association of Physical Medicine
British Association of Urological Surgeons
British Dental Association

*British Geriatrics Society
British Medical Association
British Orthopaedic Association
*British Paediatric Association
*British Postgraduate Medical Federation
*Central Consultants and Specialists Committee, United Kingdom
*Central Consultants and Specialists Committee, Scotland
College of General Practitioners
*Conference of Deans of Metropolitan Medical Schools
*Conference of Deans of Provincial Medical Schools
Faculty of Medicine, University of Aberdeen
Faculty of Medicine, University of Edinburgh
Faculty of Medicine, University of St. Andrews
*Faculty of Ophthalmologists
*Faculty of Radiologists
*General Medical Services Committee
General Practice Reform Association
Group for the Representation of the Views of Clinical Psychiatrists
Guy's Hospital Medical Committee
Hexham Group Medical Advisory Committee
*Hospital Junior Staffs Group of the British Medical Association
*Hospital Junior Staffs Group (Scotland)
*Joint Tuberculosis Council
Medical Practitioners' Union
*Medical Society for the Study of Venereal Diseases
Medical Staff Committee of Kettering General Hospital
Medical Superintendents Society
North East Metropolitan Region Pathologists
*Northern Ireland Branch of British Medical Association
Orthopaedic Group of the British Medical Association
Peripheral Hospitals in the Western Region of Scotland (ad hoc Committee)
Regional Hospitals Consultants and Specialists Association
*Royal College of Ohstetricians and Gynaecologists
*Royal College of Physicians, Edinhurgh
*Royal College of Surgeons, Edinhurgh
Royal College of Surgeons of England
*Royal Faculty of Physicians and Surgeons of Glasgow
*Royal Medico-Psychological Association
*Senior Hospital Medical Officers Group of the British Medical Association
*Society of British Neurological Surgeons
*Society of Medical Officers of Health
*Society of Thoracic Surgeons of Great Britain and Ireland
*Sub-Committee of the Central Consultants and Specialists Committee on the Training of Specialists
Time-Expired Senior Registrars Group
*Tuherculosis and Diseases of the Chest Group Committee of the British Medical Association
*Venereologists Group of the British Medical Association
*Whole-time Consultants Association
*The 1942 Club

INDIVIDUALS

Mr. W. Stirk Adams, F.R.C.S., L.R.C.P.
Dr. J.A. Black, M.D., M.R.C.P.
Dr. H.W. Chadfield, M.R.C.S., L.C.R.P.
Mr. M.C. Hardie
Dr. S. Krauss, M.D., Ph.D., M.Sc., F.B.Ps.S.
Dr. J.A.H. Lee, M.D., D.P.H., Dr. J.N. Morris, F.R.C.P., D.C.H., D.P.H., Dr. S.L. Morrison, M.B., Ch.B., D.P.H. (Joint evidence)
Dr. G. Lowe, M.B., F.R.C.S.
Dr. D.E. Meredith, M.D., M.R.C.P.
Mr. R. de Soldenhoff, M.B., F.R.C.S., F.R.C.O.G.
Mr. R. Ogier Ward, O.B.E., D.S.O., M.C., T.D., F.R.C.S.
Mr. J.K. Willson-Pepper, F.R.C.S., L.R.C.P.
Dr. F.H. Young, L.M.S.S.A.

ORAL EVIDENCE ONLY

British Association of Neurologists
British Cardiac Society
British Institute of Radiology
Chairmen of the Medical Practices Committees
Chest and Heart Association
Dr. J.H. Hunt, D.M., M.R.C.P.
Institute of Diseases of the Chest
Dr. E. James, M.D., D.P.H.
Radiologists Group of the British Medical Association
Dr. A. Talbot Rogers, M.B., B.S.
Dr. G. Swift, B.M., B.Ch.

Appendix 2.

(*Paragraph* 10 *of Report*)

SENIOR HOSPITAL MEDICAL OFFICERS*

1. The extent to which the medical establishments of hospitals should include senior hospital medical officer posts has been discussed with the profession and the following paragraphs embody the agreement which has been reached in the fields in which such posts are appropriate.

2. *Future Appointments to established consultant posts*

Consultant posts in the medical establishments of hospitals should not be filled by senior hospital medical officers except where, after advertisement, no candidate applies who is regarded as of consultant status by the appropriate Advisory Appointments Committee, but the post cannot be left vacant if the essential needs of the service are to be met.

In these exceptional circumstances, a Board should not offer the vacant appointment to one of the applicants as a senior hospital medical officer post, but should take the following steps:

(*a*) consider whether by a re-arrangement of the duties of the appointment the field of applicants of consultant status could be extended;

(*b*) if this course is not practicable or fails to attract candidates of consultant status, the vacancy may be re-advertised as a senior hospital medical officer post.

3. *Appointment of part-time general practitioners to senior hospital medical officer posts*

Boards should not overlook the possibility that in some specialties general practitioners may be qualified for part-time appointments on the senior hospital medical officer scale—for instance as Assistant Anaesthetists, Assistant Geriatricians, Assistant Paediatricians or as medical officers in charge of small infectious diseases hospitals.

4. *Revision of establishments: effect on existing officers*

Boards should now proceed to revise their establishments, making proper provision for senior hospital medical officer posts in accordance with the principles set out below. Any such revision should not, however, be allowed to affect the personal status of the officers at present holding a post the status of which is changed as a result of the revision. This means that practitioners personally graded as senior hospital medical officers who are holding consultant posts or those personally graded as consultants holding posts which become

*It should be made clear that, although the term "senior hospital medical officer" is used here and elsewhere as a convenient phrase for identifying and describing a particular grade and salary scale, there is every advantage (provided the grade is made clear) in describing the posts concerned in terms of the specialty involved, *e.g.* Assistant Anaesthetist, Assistant Paediatrician, etc.

senior hospital medical officer posts should retain their present personal status. When such a post becomes vacant, however, it should be advertised with its revised status, and a new appointment made in accordance with the grading of the post.

5. (*a*) *Specialties in which establishments should not provide for senior hospital medical officer posts, except in the circumstances set out below (such specialties being marked*)*

*Anaesthetics
General Medicine
General Surgery (including urology, proctology, *orthopaedics and *ophthalmology)
Obstetrics and Gynaecology (practised together)
Cardiology
Dermatology
Otolaryngology
Neurology
Neurosurgery
*Paediatrics
*Pathology
*Psychiatry and Mental Deficiency
Plastic Surgery
*Radiology
Thoracic Surgery

(*b*) *Specialties in which establishments may provide for senior hospital medical officer posts*

These specialties are set out in alphabetical order, specifying in each case the type or types of appointment for which senior hospital medical officer posts are appropriate.

Blood Transfusion

Posts below that of Director of Regional Blood Transfusion Service.

Diseases of the Chest

Posts in a restricted part of this field—e.g. limited to routine tuberculosis dispensary work only; posts as medical officers of sanatoria either in charge of small units or below the rank of superintendent in charge; and posts as assistant to a consultant in charge.

Geriatrics

Posts below the rank of head of a large department; and other posts where the scope for investigation and active treatment or the clinical responsibility is insufficient to justify consultant status.

Infectious Diseases

Medical Superintendents of small hospitals; at other hospitals posts below that rank.

Obstetrics (practised alone)

(1) Posts at ante-natal and post-natal clinics.

(2) Posts in maternity departments which are under the general supervision of a consultant.

Ophthalmology

Posts primarily concerned with non-operative work (e.g. refraction)

Orthopaedics

Posts primarily concerned with non-operative work.

Paediatrics

Posts at welfare centres and other posts primarily concerned with child welfare.

Physical Medicine

Post of officer in charge of a small clinic; in large departments posts other than head of the department.

Psychiatry and Mental Deficiency

(1) Posts of medical superintendent of small institutions; at larger mental institutions some posts below that rank.

(2) Posts primarily concerned with limited fields of psychiatry.

Venereal Disease.

As for Physical Medicine.

(*c*) *Specialties in which establishments may provide for assistantships to consultants remunerated on the S.H.M.O. scale*

Anaesthetics

Hospital establishments should include an adequate complement of widely experienced anaesthetists of consultant status (vide paragraphs 79 to 81 of the pamphlet "Development of Consultant Services").

In addition to this complement of consultants and to trainees, there will often be a need in some hospitals for Assistant Anaesthetists remunerated on the senior hospital medical officer scale.

Pathology

The staff of a pathological department should consist of consultants and trainees as appropriate, with a limited field for the appointment of Assistant Pathologists remunerated on the senior hospital medical officer scale.

The complement of consultants must depend on the size of the department but in any event, where there are separate sections each in the charge of a pathologist under the general control of the head of the department (e.g. morbid anatomy, biochemistry, haematology, bacteriology, blood transfusion) each should be of consultant status.

Radiology and Radiotherapy

The establishment of radiodiagnostic or radiotherapeutic departments should include at least one practitioner of consultant status with trainees as appropriate. Where the complement of consultants and trainees is not sufficient to deal with the work of the department, it may be necessary to appoint Assistant Radiologists of narrower training and with more limited responsibility than the consultant, remunerated on the senior hospital medical officer scale.

6. *Specialties not mentioned above*

Boards should not establish any consultant or S.H.M.O. post in a specialty not mentioned above without the approval of the Ministry.

MINISTRY OF HEALTH,
WHITEHALL, S.W.1.
3rd October, 1950.

Appendix 3

Statistical Tables

TABLE A

(*Paragraphs* 19 *and* 37 *of Report*)

Consultants—Specialty Distribution

1952 *and* 1959

GREAT BRITAIN

Specialty (1)	End of 1952		End of 1959		Increase (+) or Decrease (—) in numbers 1959 compared with 1952 (6)
	Number (2)	Percentage of total (3)	Number (4)	Percentage of total (5)	
General Medicine (including Geriatrics and Cardiology)	904	13·2	1019	12·9	+ 115
Chest Diseases	311	4·5	330	4·2	+ 19
Mental Illness and Mental Deficiency	566	8·2	724	9·2	+ 158
Neurology	61	0·9	86	1·1	+ 25
Paediatrics	214	3·1	243	3·1	+ 29
Radiology	414	6·0	522	6·6	+ 108
Radiotherapy	108	1·6	137	1·7	+ 29
Physical Medicine	69	1·0	88	1·1	+ 19
Pathology	582	8·5	781	9·9	+ 199
Infectious Diseases	51	0·7	49	0·6	— 2
Dermatology	142	2·1	160	2·0	+ 18
Venereology	97	1·4	82	1·0	— 15
Opbthalmology	350	5·1	342	4·3	— 8
General Surgery (including Urology) ...	987	14·4	1002	12·7	+ 15
Anaesthetics	714	10·4	869	11·0	+ 155
Neurosurgery	44	0·6	66	0·8	+ 22
Plastic Surgery...	36	0·5	62	0·8	+ 26
Thoracic Surgery	81	1·2	102	1·3	+ 21
Traumatic and Orthopaedic Surgery	320	4·7	376	4·8	+ 56
Ear, Nose and Throat ...	339	5·0	344	4·4	+ 5
Obstetrics and Gynaecology ...	473	6·9	509	6·5	+ 36
All Specialties	6863	100·0	7893	100·0	+1030

The comparative distribution viewed on a broader functional basis was as follows:

Specialties	Number of Consultants		Increase 1959 compared with 1952	
	1952	1959	Number	Percentage
Medical	1,849	2,057	208	11·2
Surgical	2,157	2,294	137	5·8
Obstetrics and Gynaecology	473	509	36	7·6
Mental Illness and Mental Deficiency ...	566	724	158	27·9
Radiology and Radiotherapy	522	659	137	26·2
Pathology	582	781	199	34·2
Anaesthetics	714	869	155	21·7
Totals	6,863	7,893	1,030	15·0

Notes: (1) The figures represent all consultants eligible for distinction awards whether holding a paid appointment or an honorary one in the Hospital Service.

(2) Some consultants who practise in more than one specialty are counted in each. For this reason the total for all specialties for 1959 exceeds the figures of the actual number of consultants in 1959 given in the body of the report.

(3) In the smaller table the group of medical specialties consists of General Medicine (including Geriatrics and Cardiology), Chest Diseases, Neurology, Paediatrics, Physical Medicine, Infectious Diseases, Dermatology and Venereology. The surgical group consists of General Surgery (including Urology), Ophthalmology, Neurosurgery, Plastic Surgery, Thoracic Surgery, Traumatic and Orthopaedic Surgery and Ear, Nose and Throat.

TABLE B(i)

(Paragraphs 19 and 38 of Report)

Consultants—Age Distribution 1952 and 1958

ENGLAND AND WALES

Approximate age groups	Consultants at mid-1952			Consultants at mid-1958		
	Year of Birth	Number	Percentage of total	Year of Birth	Number	Percentage of total
Over 65	Before 1887	79	1·3	Before 1893	49	0·7
65–62	1887–90	292	4·8	1893–96	340	5·0
61–58	1891–94	387	6·4	1897–00	708	10·4
57–54	1895–98	553	9·1	1901–04	849	12·5
53–50	1899–02	900	14·9	1905–08	909	13·4
49–46	1903–06	854	14·1	1909–12	1,079	15·9
45–42	1907–10	989	16·3	1913–16	1,345	19·8
41–38	1911–14	1,055	17·4	1917–20	1,023	15·1
37–34	1915–18	796	13·1	1921–24	457	6·7
Under 34	After 1918	157	2·6	After 1924	36	0·5
Totals	—	6,062	100·0	—	6,795	100·0

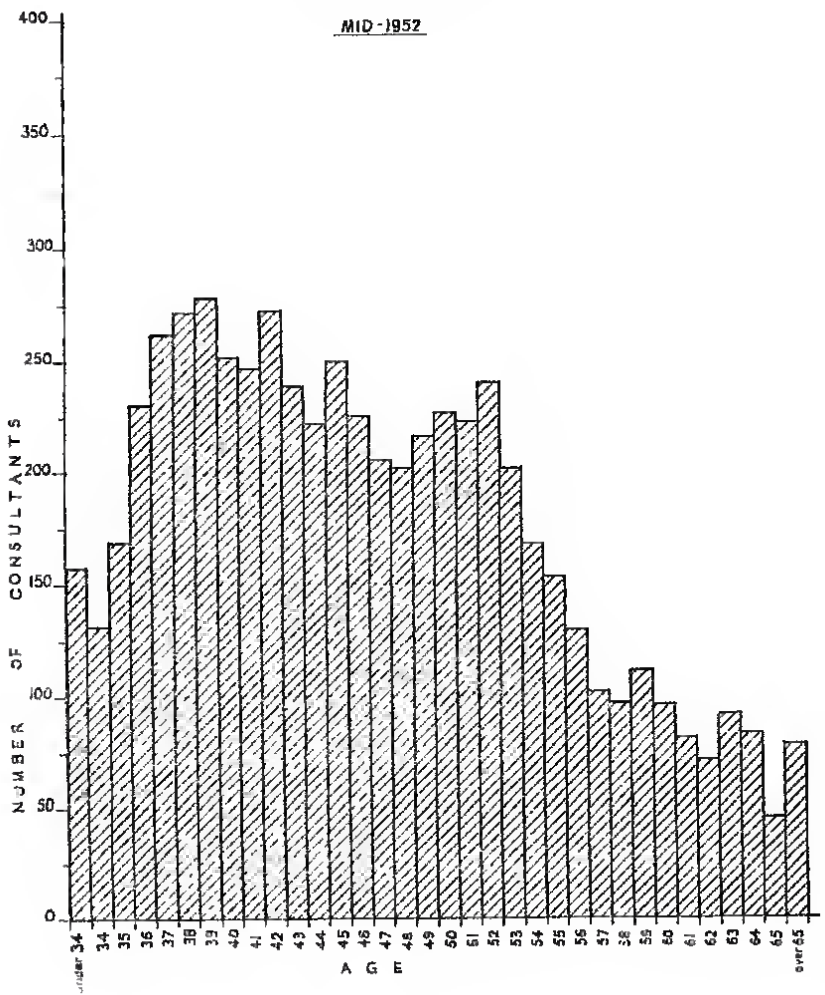
Notes: (1) The table has been drawn with the object of showing the number and proportion of consultants in four-year age groups. The age groups are approximate in the sense that all consultants who were born *e.g.* in 1887 have been regarded as being age 65 in the middle of 1952: in fact some would have been up to six months below that age. As this factor applies throughout, the size of the various four-year groups should not be affected significantly.

(2) As the figures have been compiled from figures relating to the separate specialties there is some duplication owing to consultants who practise two specialties being included in the figures relating to each: the number is not however large—see Note (2) to Table A.

(3) Honorary consultants are included.

The comparison is displayed below in the form of a diagram.

AGE DISTRIBUTION OF CONSULTANTS - ENGLAND AND WALES



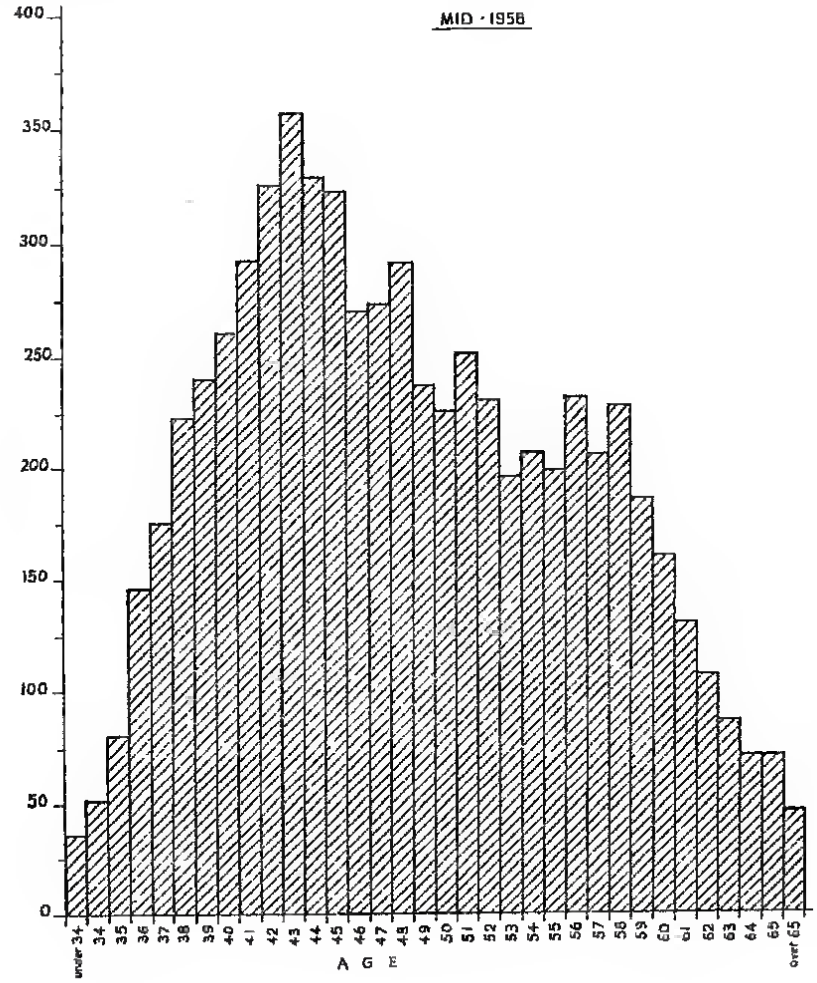


TABLE B(ii)

(Paragraphs 19 and 38 of Report)

Consultants—Age Distribution at 30th June, 1958

SCOTLAND

Approximate age groups	Year of Birth	Number	Percentage of Total
Over 65	Before 1893	8	0·9
65–62	1893–96	57	6·3
61–58	1897–00	76	8·5
57–54	1901–04	102	11·4
53–50	1905–08	93	10·3
49–46	1909–12	167	18·6
45–42	1913–16	195	21·7
41–38	1917–20	118	13·1
37–34	1921–24	72	8·0
Under 34	After 1924	11	1·2
Totals	—	899	100·0

Note: Notes (1) and (3) to Table B(i) apply.

TABLE C

(Paragraphs 19 and 63 of Report)

Senior Registrars—Specialty Distribution

GREAT BRITAIN

1st July, 1959

Specialty	Number of approved Training Posts	Number of Senior Registrars employed
General Medicine	166	191
Diseases of the Chest	55	33
Mental Health	174	161
Neurology	14	16
Paediatrics	34	40
Radiology	80	69
Radiotherapy	18	18
Physical Medicine	14	12
Pathology	87	120
Infectious Diseases	4	4
Dermatology	27	28
Venereology	7	4
Ophthalmology	58	65
General Surgery	169	212
Anaesthetics	103	100
Neuro-surgery	14	11
Plastic Surgery	16	16
Thoracic Surgery	18	25
Orthopaedic Surgery	60	67
Ear, Nose and Throat	46	49
Obstetrics and Gynaecology ...	84	98
Totals	1,248	1,339

Notes: (1) The figures in the third column include honorary senior registrars.

(2) There has so far been no formal reduction in the number of training posts where the future requirements of a specialty are likely to be less than was originally anticipated, but in such a specialty, of which Chest Diseases is the outstanding example, informal arrangements are made to secure an appropriate reduction in the number of senior registrars appointed.

TABLE D(i)

(Paragraphs 19 and 65 of Report)

Senior Registrars—Age Distribution by Specialty Groups

1st July, 1958

ENGLAND AND WALES

Appropriate age group	Year of birth	Specialty Group							
		Medical group	Surgical group	Obstetrics and Gynaecology	Mental Illness and Mental Deficiency	Radiology and Radiotherapy	Pathology	Anaesthetics	Total
Over 45	Before 1913	5	8	3	7	2	1	—	26
45—42	1913—16	18	17	8	10	3	8	2	66
41	1917	7	15	4	1	1	—	—	28
40	1918	12	13	2	1	1	—	—	29
39	1919	8	29	4	3	1	2	1	48
38	1920	16	23	9	7	5	5	3	68
37	1921	21	41	4	10	4	—	3	83
36	1922	26	38	7	9	4	3	2	89
35	1923	37	49	4	9	4	10	5	118
34	1924	41	33	10	11	5	9	8	117
33	1925	29	38	12	16	10	6	12	123
32	1926	25	24	5	13	9	11	11	98
31	1927	15	15	2	11	10	5	20	78
30 or less	1928 or later	7	7	—	12	6	3	9	44
Totals ...	—	267	350	74	120	65	63	76	1,015

Notes: (1) Honorary senior registrars are included.

(2) The specialties included in the medical and surgical groups are those listed in the note at the end of Table A.

TABLE D(ii)

(Paragraphs 19 and 65 of Report)

Senior Registrars—Age Distribution by Specialty Groups

30*th June*, 1960.

SCOTLAND

Appropriate age group	Year of birth	Specialty Group							
		Medical	Surgical	Obstetrics and Gynaecology	Psychiatry	Radiology and Radiotherapy	Pathology (including Bacteriology)	Anaesthetics	Total
Over 45	Before 1915	3	—	—	—	—	2	—	5
45—42	1915—18	3	1	3	1	1	3	—	12
41	1919	4	3	—	1	—	—	—	8
40	1920	3	7	1	2	1	3	—	17
39	1921	1	10	2	1	—	2	1	17
38	1922	9	4	1	2	1	2	—	19
37	1923	12	8	—	1	1	5	1	28
36	1924	9	5	1	3	—	5	2	25
35	1925	7	6	3	1	4	4	1	26
34	1926	9	8	1	1	3	6	2	30
33	1927	7	20	5	5	2	1	4	44
32	1928	5	6	—	6	1	4	2	24
31	1929	1	3	—	3	1	4	3	15
30 or less	1930 or later	2	5	—	3	1	2	2	15
Not known		1	1	2	—	—	5	—	9
Totals ...		76	87	19	30	16	48	18	294

Note: (1) Honorary senior registrars are included.

(2) The specialties included in the medical and surgical groups are those listed in the note at the end of Table A.

TABLE E

(Paragraphs 19 and 116 of Report)

Senior Hospital Medical Officers—Specialty Distribution

1953 *and* 1958

GREAT BRITAIN

Specialty (1)	1953 Number (2)	1953 Percentage of total (3)	1958 Number (4)	1958 Percentage of total (5)	Increase (+) or decrease (—) in number 1958 compared with 1953 (6)
General Medicine (including Geriatrics and Cardiology)	222	8·9	224	8·9	+ 2
Chest Diseases	388	15·5	429	17·1	+41
Mental Illness and Mental Deficiency	391	15·6	451	18·0	+60
Neurology	8	0·3	8	0·3	—
Paediatrics	23	0·9	20	0·8	— 3
Radiology	78	3·1	61	2·5	—17
Radiotherapy	36	1·4	38	1·5	+ 2
Physical Medicine	22	0·9	27	1·1	+ 5
Pathology	159	6·3	195	7·8	+36
Infectious Diseases	74	3·0	85	3·4	+11
Dermatology	51	2·0	30	1·2	—21
Venereology	80	3·2	78	3·1	— 2
Ophthalmology	241	9·6	254	10·1	+13
General Surgery (including Urology)	217	8·7	120	4·8	—97
Anaesthetics	317	12·6	296	11·8	—21
Neurosurgery	1	—	1	—	—
Plastic Surgery...	1	—	1	—	—
Thoracic Surgery	2	0·1	2	0·1	—
Traumatic and Orthopaedic Surgery	55	2·2	69	2·8	+14
Ear, Nose and Throat ...	37	1·5	35	1·4	— 2
Obstetrics and Gynaecology	105	4·2	83	3·3	—22
Totals	2,508	100	2,507	100	— 1

The figures for the same specialty groups as are used in Table A for consultants are as follows:

Specialties	Number of Senior Hospital Medical Officers		Increase (+) or decrease (—) 1958 compared with 1953	
	1953	1958	Number	Percentage
Medical Group	868	901	+33	+ 4
Surgical Group	554	482	—72	—13
Obstetrics and Gynaecology	105	83	—22	—21
Mental Illness and Mental Deficiency ...	391	451	+60	+15
Radiology and Radiotherapy	114	99	—15	—13
Pathology	159	195	+36	+23
Anaesthetics	317	296	—21	— 7
Totals...	2,508	2,507	— 1	—

Notes: (1) A small number of senior hospital medical officers—about 15—practising in more than one specialty is counted in each in 1958.

(2) Honorary staff included.

TABLE F(i)

(*Paragraphs* 19 *and* 118 *of Report*)

Senior Hospital Medical Officers—Age Distribution

1953 *and* 1958

ENGLAND AND WALES

Approximate age groups	S.H.M.Os. at mid-1953			S.H.M.Os. at mid-1958		
	Year of Birth	Number	Percentage of total	Year of Birth	Number	Percentage of total
Over 65	Before 1888	20	1·0	Before 1893	18	0·8
65–62	1888–91	92	4·1	1893–96	125	5·7
61–58	1892–95	143	6·4	1897–00	250	11·5
57–54	1896–99	276	12·4	1901–04	268	12·3
53–50	1900–03	316	14·2	1905–08	268	12·3
49–46	1904–07	263	11·8	1909–12	278	12·8
45–42	1908–11	312	14·0	1913–16	357	16·4
41–38	1912–15	334	15·0	1917–20	291	13·4
37–34	1916–19	305	13·7	1921–24	245	11·3
Under 34	After 1919	164	7·4	After 1924	77	3·5
Totals	—	2,225	100·0	—	2,177	100·0

Notes: (1) Note (1) to Table B(i) applies.

(2) As the figures have been compiled from figures relating to the separate specialties there is some duplication owing to doctors who practise two specialties being included in the figures relating to each: the number is small—see Note (1) on Table E.

(3) Honorary staff are included.

TABLE F(ii)

(Paragraphs 19 and 118 of Report)

Senior Hospital Medical Officers

Age Distribution at 30th June, 1958

SCOTLAND

Approximate age groups	Year of Birth	Number	Percentage of total
Over 65	Before 1893	4	1·2
65–62	1893–96	9	2·7
61–58	1897–00	24	7·3
57–54	1901–04	24	7·3
53–50	1905–08	17	5·2
49–46	1909–12	38	11·5
45–42	1913–16	59	17·9
41–38	1917–20	65	19·7
37–34	1921–24	61	18·4
Under 34	After 1924	29	8·8
Totals	—	330	100·0

Note: Notes (1) and (3) to Table F(i) apply.

Appendix 4.

(Paragraph 95 of Report)

The Census of Certain Grades of Medical Staff employed wholetime on 31st March, 1960

Average Length of Service in the Junior Grades and Statistical Tables.

Note by the Ministry of Health and the Department of Health for Scotland

1. In order to assist the Working Party in their general study of the staffing structure and in particular to ohtain information about the length of time doctors entering the junior medical grades are spending on average in these grades, the Health Departments, at the Working Party's request, asked all hospital authorities in Great Britain to provide certain particulars ahout each memher of their medical staff, employed wholetime on 31st March, 1960, in the grades of house officer (provisionally registered), house officer (fully registered), senior house officer, junior hospital medical officer and registrar. These particulars were:

(1) Name
(2) Year of birth
(3) Year of qualification
(4) Sex
(5) Date of first hospital employment in Great Britain
(6) Whether or not National Service has been undertaken and, if so, whether hefore or after qualification
(7) Present grade
(8) Country of birth and country in which qualified
(9) Whether or not employed in present post as a locum
(10) Whether or not employed solely by the reporting authority
(11) Specialty in which mainly employed.

Returns were received from all hospital authorities and it is therefore presumed that the census provides a complete record of all doctors employed in the specified grades on 31st March, 1960.

2. The census was restricted to doctors employed wholetime in the specified grades because it is unusual for doctors to be employed for part-time service in these grades and the inclusion of the relatively few who are so employed would have introduced an uncharacteristic element.

3. Information was also obtained of the number of vacant posts, classified hy specialty, in each of the grades in question at 31st March, 1960. For this purpose a vacant post was so defined as to limit this information to vacancies which positive steps were heing taken to fill in the near future irrespective of whether locums were acting in them in the interim.

4. Detailed tables of statistics derived from the enquiry have been supplied to the Working Party. The purpose of this memorandum is to summarise the main sets of figures and to provide an estimate of the time doctors are spending in the junior grades.

5. The enquiry shows that the number of doctors employed in the grades at 31st March, 1960, was 9,543. This figure includes 446 locums. The distribution of the 9,543 among grades is shown below:

	Number employed excluding locums	*Number of locums*
Registrars	3,110	156
Junior Hospital Medical Officers ...	776	77
Senior House Officers	2,456	160
House Officers (fully registered) ...	813	26
House Officers (provisionally registered)	1,942	27
Total	9,097	446

6. The number of vacant posts was 873, distributed among grades as follows:

Registrars	291
Junior Hospital Medical Officers	106
Senior House Officers	261
House Officers (fully registered)	26
House Officers (provisionally registered) ...	189

These vacancies include those posts in which locums were acting pending the making of regular appointments. The total number of posts which were filled by regular appointments or were waiting to be filled at the census date was 9,970. 125 of the vacancies were in teaching hospitals.

7. The annexure contains the following tables summarising various information derived from the census:

Table 1 — Classification by grade and sex

2 — Classification by year of qualification and period since first hospital appointment

3 — Classification by grade and age

4 — Classification by grade and specialty

5 — Classification by region and grade

6 — Proportionate contribution to junior staffing in regions made by doctors from overseas.

AVERAGE LENGTH OF SERVICE IN THE JUNIOR MEDICAL GRADES

8. The following paragraphs describe the data required and the methods used to calculate the average length of service in the junior medical grades.

9. *Sources of information*

(*a*) Figures were obtained from the Deans of Medical Schools of the number of students graduating during the years 1955-59. For 1953 and 1954 information provided for the National Medical Manpower Committee was used. Details for the years 1953-59 are given in the following table:

Year of Qualification	British Doctors		Other Doctors
	Male	Female	
1953	1,500	410	*
1954	1,470	360	*
1955	1,370	430	100
1956	1,484	395	102
1957	1,366	416	117
1958	1,313	362	142
1959	1,314	393	146

*No information available

(*b*) The census provided information about the numbers of British doctors who qualified in Great Britain, analysed by sex, year of qualification and years of hospital service.

'Years of hospital service' means the total period between first appointment to a hospital in Great Britain and the date of the census, reduced by two years in those cases where British doctors had completed National Service since qualification. It is strictly accurate only where service in British hospitals is continuous from the date of first hospital appointment.

Periods of service were extremely varied as might be expected from a census which included on the one hand doctors in grades such as provisionally registered house officer, where the normal period of tenure was short, and on the other hand junior hospital medical officers, many of whom hold posts of unlimited tenure.

(*c*) The Service departments were asked to supply information about the number of doctors who held National Service commissions at 31st March, 1960. By using the Medical Register this information was analysed by year of qualification. A small number of Irish doctors were included. Details are given in the following table:

Doctors holding National Service commissions at 31*st March*, 1960

Year of Qualification	1954	1955	1956	1957	1958	1959
Number of Doctors	1	8	92	260	196	8

10. *Description of methods used to obtain a distribution of length of service in the junior medical grades.*

Estimates of the distribution of length of service in the junior medical grades by British doctors were calculated from the information detailed above.

Doctors who qualified in a given year were assumed to have had the opportunity to complete a certain maximum period of service before 31st March, 1960, e.g. doctors who qualified during 1959 were assumed to have had the opportunity to complete no more than one year of service, although a small number of doctors in this group will have had the opportunity to complete slightly more than one year of service. Similarly doctors who qualified in 1958 were assumed to have had the opportunity to complete between one and two years of service and so on. The number of doctors in the census who qualified in a given year and who completed the 'maximum' period of service was expressed as a percentage of the total number of doctors who were assumed to have had the opportunity to complete the maximum period of service.

The denominator included all British doctors who qualified in Great Britain other than doctors who held National Service commissions on 31st March, 1960, and doctors included in the census who had completed less than the 'maximum' period of service.

It was not possible to obtain information about the total number of doctors excluded from the census because they were in between hospital posts or who for other reasons had temporarily interrupted their service in the junior medical grades.

However it was found that 12 per cent of British doctors who qualified in 1959 from medical schools in Great Britain were not included in the census or in the number of doctors holding National Service Commissions. It is possible that a few of these doctors may have qualified in the first quarter of 1959, completed their year of provisional registration and taken up other forms of medical work, but the main explanation appears to be that these doctors were in between hospital posts on 31st March, 1960. This hypothesis is strengthened by information submitted by the Deans that only an insignificant number of British graduates do not enter the Hospital Service for the year of provisional registration.

Thus an allowance was made for the service of doctors awaiting posts. This was very approximate and was done by scaling up to a hundred the percentage of doctors in post who qualified in 1959, after excluding the very few doctors in this group who held National Service commissions on 31st March, 1960, and adjusting the remaining percentages proportionately.

11. *Distribution of Service of British Doctors who qualified in Great Britain.*

Year qualified	Maximum period of hospital service	Number of doctors in census with maximum period of service	Total number of British doctors who qualified from medical schools in Great Britain	Total number of National Service doctors and those in the census with less than maximum period of service	Col.(4) — Col.(5)	Percentage of doctors who completed the maximum period of service i.e. Col. (3) as a percentage of Col. (6)	Percentage of doctors who completed the maximum period of service adjusted for service of doctors awaiting posts
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1959	Less than 1 year	1,498	1,707	8	1,699	88	100
1958	1 but not 2 years	822	1,675	205	1,470	56	64
1957	2 but not 3 years	470	1,782	273	1,509	31	35
1956	3 but not 4 years	344	1,879	247	1,632	21	24
1955	4 but not 5 years	315	1,800	223	1,577	20	23
1954	5 but not 6 years	218	1,830	224	1,606	14	16
1953	6 but not 7 years	140	1,910	143	1,767	8	9
1952	7 but not 8 years	147	*1,910	158	1,752	8	9
1951	8 but not 9 years	67	*1,910	152	1,758	4	4
1950	9 but not 10 years	66	*1,910	83	1,827	4	4
1949	10 but not 11 years	45	*1,910	43	1,867	2	2

*No information available for the years 1949–1952.

12. It ean be seen that the distribution of length of serviee given in Col.(8) of the preceding table is a series of figures each of whieh is an estimate of the percentage of doctors remaining in the relcvant grades at the 31st March, 1960, after providing the maximum period of service. National Servieemen and doctors (mainly ex-Service) ineluded in the census who had not provided the maximum period of service have been excluded from the caleulations.

It is impossible to give a preeise estimate of the average length of service resulting from the distribution of serviee given in Col.(8) of the preceding table, which does not involve additional assumptions about the distributions of exits during a particular year. Whilst it can be assumed with reasonable certainty that all British doetors who eommenee a year of provisional registration are likely to eomplete the full year, it is impossible to say from available information whether exits during the seeond year are uniformly distributed throughout the year or whether they take place at diseontinuous intervals, for example at eighteen months or at the end of the year. If it can be assumed that the percentages given in Col.(8) hold throughout the year, that is that all exits take place at the end of the year, the overall period of serviee is 3·0 years. However it seems reasonable to suggest that the true figure lies within a range of 3 years $\pm$ 3 months. All these figures disregard service in the junior medieal grades in excess of fifteen years. The service of approximately 400 doetors who qualified in 1948 or earlier has been exeluded from the calculations for a number of reasons, one being that this serviee is unlikely to be typieal in present eireumstances.

13. The result obtained for the average period of service in the junior medical grades has been verified by a more direct method. A sample of names of doctors who qualified in a given year was taken and information about the length of service in the grades was found and also the number and length of breaks in

service and the date of exit, an exit being defined as the termination of service in the junior medical grades whether by reason of an appointment to a senior post in the hospital medical service or because the doctor finally left the service. The distribution of years of hospital service obtained by this method was in close agreement with that obtained in the previous paragraph.

14. The average period of service given by doctors recruited from other sources is more difficult to estimate because there is no reliable information about the total annual recruitment from these sources which comprise British doctors who qualified overseas, Irish doctors and other nationals. The total numbers of these doctors included in the census are shown below by years of service in British hospitals.

Years of service in British Hospitals	*Number of Doctors*
Under 1 year	1,228
1 but less than 2 years	709
2 „ „ 3 years	487
3 „ „ 4 years	384
4 „ „ 5 years	242
5 „ „ 6 years	182
6 „ „ 7 years	148
7 „ „ 8 years	78
8 „ „ 9 years	47
9 „ „ 10 years	48
10 „ „ 15 years	123
15 years and over	84
Total ...	3,760

If the number of doctors with less than one year of service represents approximately the annual rate of recruitment in the past, it seems likely that the average period of service given by doctors recruited from these sources does not differ significantly from that given by British doctors who qualified in Great Britain.

15. The figures given in the preceding paragraphs are based on past experience and there must be some uncertainty about whether they will continue to hold good in the future. Relative changes in the attractions of other medical work may affect future distributions of service, and the imminent abolition of liability for National Service may result in permanent or temporary changes in the distribution of service in the junior medical grades.

Annexure

General Note

The figures in brackets in the various tables show the number of doctors born outside Great Britain who are included in the unbracketed figures.

Table 1

Classification by Grade and Sex

Grade	Male	Female	Total
Registrars	2727 (1179)	539 (129)	3266 (1308)
Junior Hospital Medical Officers	601 (289)	252 (89)	853 (378)
Senior House Officers	2055 (1026)	561 (223)	2616 (1249)
House Officers (fully registered)	625 (231)	214 (77)	839 (308)
House Officers (provisionally registered) ...	1523 (318)	446 (67)	1969 (385)
Totals	7531 (3043)	2012 (585)	9543 (3628)

Table 2

Classification by year of qualification and period since first hospital appointment.

Period since first hospital appointment	Year of Qualification													
	1948 or earlier	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	Total
Under 1 year	56 (54)	20 (20)	23 (21)	32 (31)	44 (43)	65 (64)	108 (103)	128 (124)	162 (158)	152 (149)	179 (166)	1711 (263)	59 (10)	2739 (1206)
1 but less than 2 ...	37 (32)	8 (8)	17 (16)	26 (26)	41 (40)	85 (84)	74 (74)	120 (117)	236 (90)	79 (65)	925 (114)	87 (11)	— —	1735 (677)
2 but less than 3 ...	22 (18)	11 (11)	11 (10)	25 (24)	36 (35)	63 (63)	91 (83)	280 (82)	62 (53)	546 (83)	28 (7)	— —	— —	1175 (469)
3 but less than 4 ...	25 (22)	13 (13)	18 (18)	28 (26)	44 (41)	57 (54)	284 (77)	61 (45)	400 (63)	27 (8)	— —	— —	— —	957 (367)
4 but less than 5 ...	24 (20)	10 (10)	15 (14)	13 (13)	38 (37)	176 (45)	51 (39)	360 (50)	19 (2)	— —	— —	— —	— —	706 (230)
5 but less than 6 ...	21 (20)	14 (12)	14 (14)	21 (18)	174 (36)	40 (28)	235 (38)	19 (6)	— —	— —	— —	— —	— —	538 (172)
6 but less than 7 ...	33 (27)	12 (12)	13 (13)	154 (24)	40 (21)	185 (43)	28 (3)	— —	— —	— —	— —	— —	— —	465 (142)
7 but less than 8 ...	26 (22)	10 (8)	74 (5)	30 (14)	162 (25)	1 (—)	— —	— —	— —	— —	— —	— —	— —	303 (74)
8 but less than 9 ...	24 (14)	45 (9)	16 (6)	76 (14)	12 (1)	— —	— —	— —	— —	— —	— —	— —	— —	173 (44)
9 but less than 10 ...	50 (25)	8 (5)	77 (16)	8 (1)	— —	— —	— —	— —	— —	— —	— —	— —	— —	143 (47)
10 but less than 15 ...	285 (104)	57 (12)	9 (4)	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	351 (120)
15 and over	258 (80)	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	258 (80)
Total	861 (438)	208 (120)	287 (137)	413 (191)	591 (279)	672 (381)	871 (416)	968 (424)	879 (366)	804 (305)	1132 (287)	1798 (274)	59 (10)	9543 (3628)

Period since first hospital appointment means the total period between first appointment to a hospital in Great Britain and the date of the census, reduced by two years in those cases where British doctors had completed National Service since qualification.

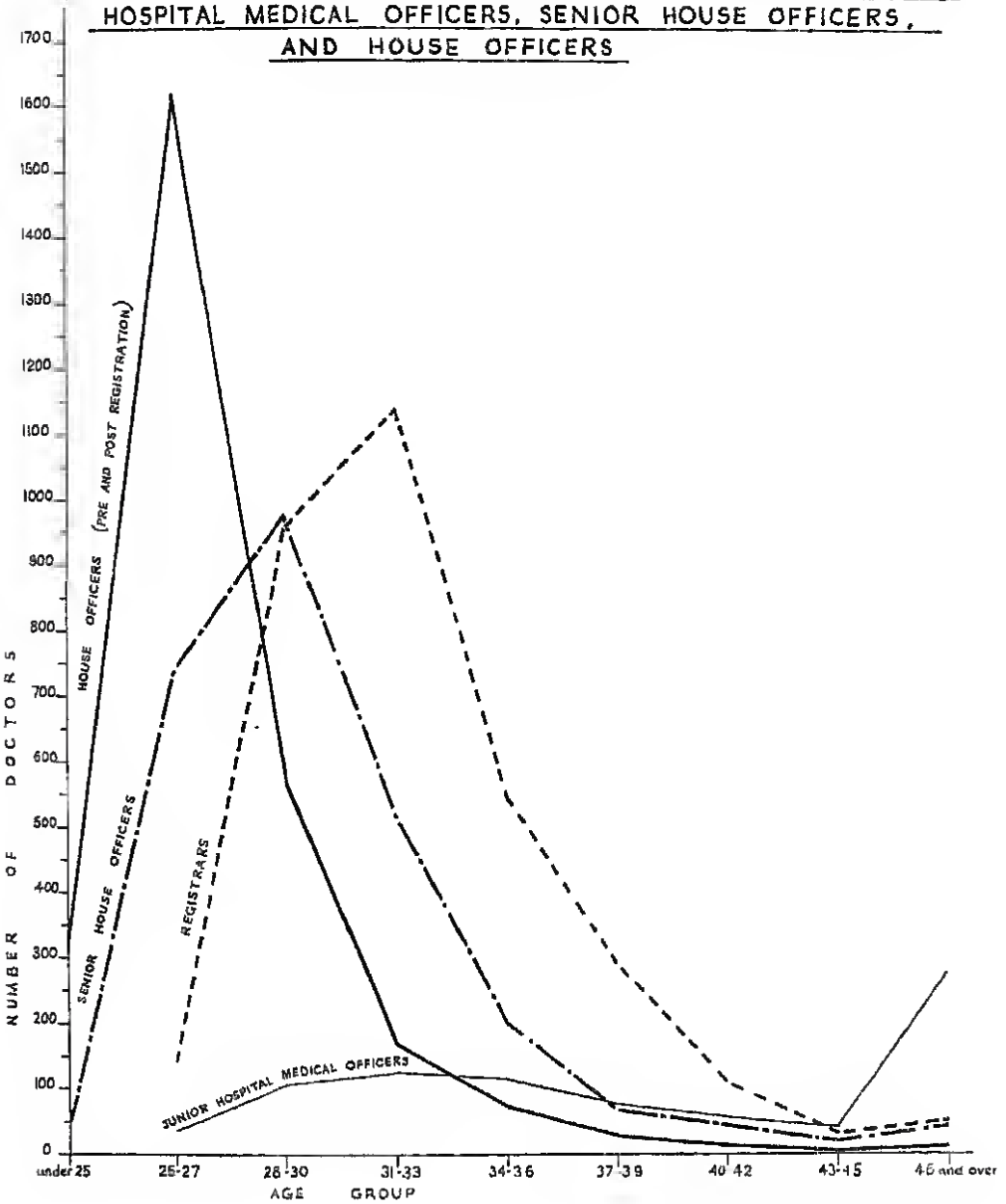
Table 3

Classification by Grade and Age

Age	Grade					Totals
	Registrar	Junior Hospital Medical Officer	Senior House Officer	House Officer (fully registered)	House Officer (provisionally registered)	
46 and over	50 (28)	259 (130)	35 (19)	7 (3)	1 (1)	352 (181)
43–45 ...	41 (18)	52 (22)	22 (15)	2 (1)	— —	117 (56)
40–42 ...	108 (51)	62 (30)	48 (33)	8 (6)	6 (3)	232 (123)
37–39 ...	287 (131)	80 (36)	76 (53)	16 (12)	14 (6)	473 (238)
34–36 ...	545 (238)	123 (53)	200 (139)	45 (32)	45 (19)	958 (481)
31–33 ...	1133 (440)	130 (59)	514 (304)	78 (44)	90 (44)	1945 (891)
28–30 ...	955 (347)	111 (36)	964 (436)	299 (118)	262 (105)	2591 (1042)
25–27 ...	147 (55)	36 (12)	736 (235)	372 (85)	1239 (169)	2530 (556)
under 25	— —	— —	21 (15)	12 (7)	312 (38)	345 (60)
Totals ...	3266 (1308)	853 (378)	2616 (1249)	839 (308)	1969 (385)	9543 (3628)

This information is shown in graph form below. Graphs are also added to show separately the age distribution of British and oversea doctors in the senior house officer and registrar grades. It should be borne in mind that some of the doctors born in Great Britain would have done two years' National Service after completing appointments as provisionally registered house officers.

AGE DISTRIBUTION AT 31ST. MARCH 1960 OF REGISTRARS, JUNIOR HOSPITAL MEDICAL OFFICERS, SENIOR HOUSE OFFICERS, AND HOUSE OFFICERS



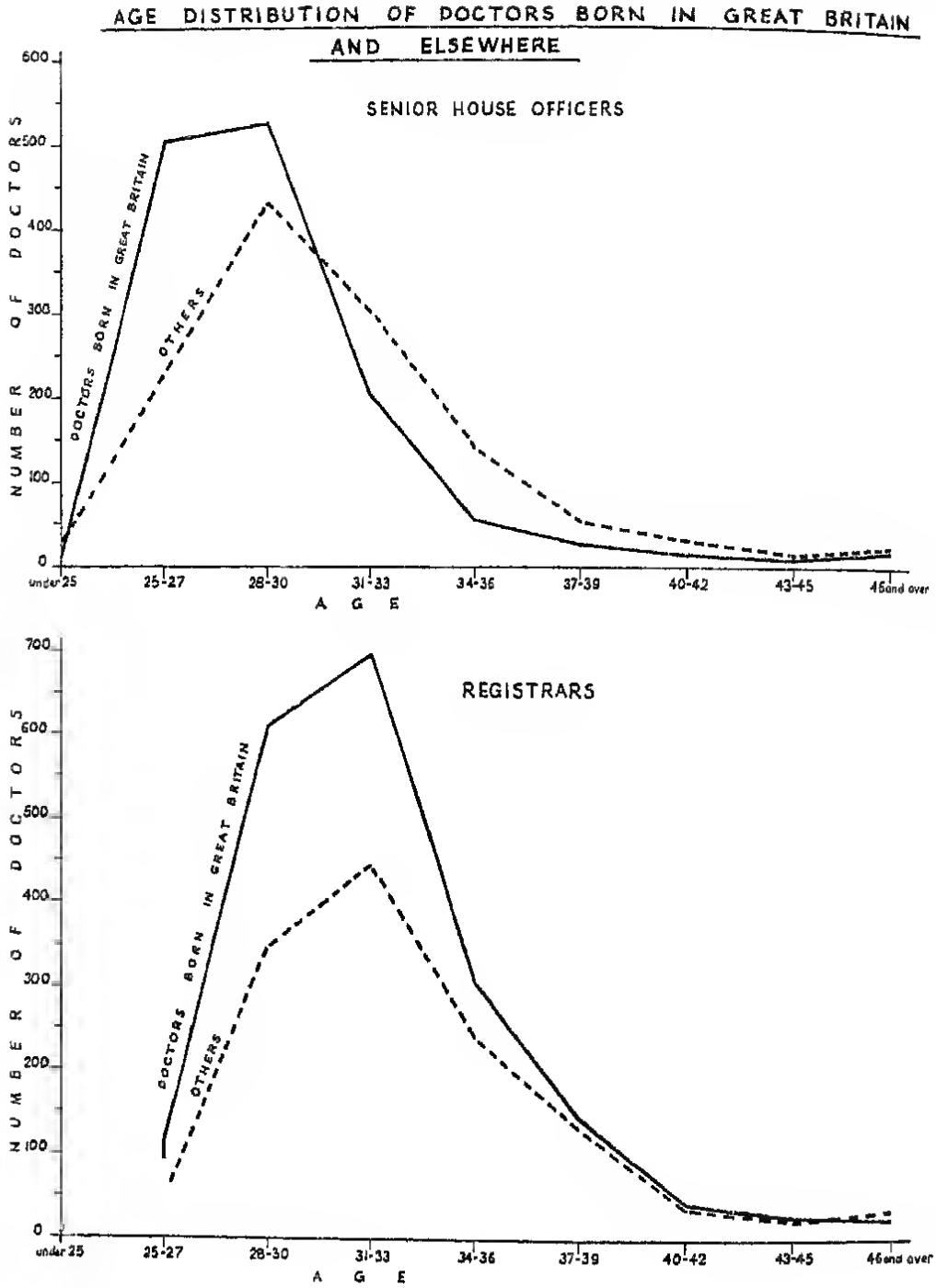


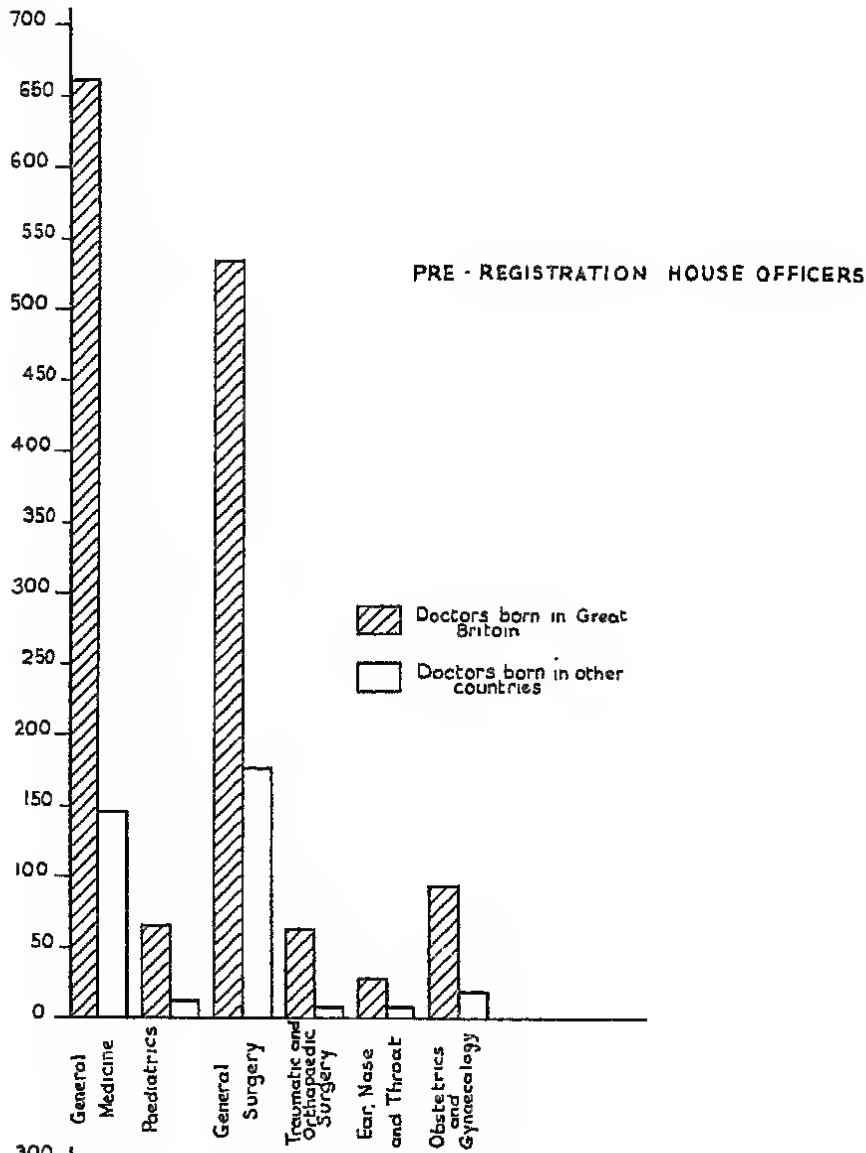
Table 4

Classification by grade and specialty

Specialty	Grade										Totals	
	Registrar		Junior Hospital Medical Officer		Senior House Officer		House Officer (fully registered)		House Officer (provisionally registered)			
General Medicine ...	474	(126)	59	(29)	343	(144)	116	(64)	807	(143)	1799	(506)
Cardiology	13	(6)	1	(1)	6	(—)	3	(2)	4	(—)	27	(9)
Geriatrics	35	(15)	48	(19)	67	(45)	3	(1)	13	(5)	166	(85)
Chest Diseases	88	(56)	83	(50)	56	(34)	24	(8)	11	(4)	262	(152)
Mental Illness	319	(98)	281	(120)	126	(42)	4	(—)	3	(—)	733	(260)
Mental Deficiency... ...	15	(4)	60	(25)	—	(—)	1	(—)	—	(—)	76	(29)
Neurology	22	(5)	1	(—)	18	(7)	3	(—)	6	(—)	50	(12)
Paediatrics	127	(44)	10	(1)	131	(50)	107	(42)	78	(12)	453	(149)
Radiology	83	(19)	—	(—)	42	(12)	—	(—)	—	(—)	125	(31)
Radiotherapy	46	(14)	7	(5)	21	(10)	2	(1)	9	(—)	85	(30)
Physical Medicine ...	24	(4)	3	(1)	2	(1)	—	(—)	2	(—)	31	(6)
Pathology	174	(27)	9	(2)	137	(30)	3	(—)	2	(—)	325	(59)
Infectious Diseases ...	15	(8)	34	(17)	31	(20)	1	(1)	14	(4)	95	(50)
Dermatology	36	(6)	2	(1)	11	(4)	4	(2)	14	(—)	67	(13)
Venereology	4	(1)	3	(—)	4	(—)	1	(—)	—	(—)	12	(1)
Ophthalmology	75	(40)	8	(3)	74	(42)	7	(5)	8	(—)	172	(90)
General Surgery	556	(303)	34	(18)	386	(253)	111	(72)	713	(180)	1800	(826)
Urology	13	(8)	1	(1)	13	(9)	3	(1)	10	(3)	40	(22)
Anaesthetics	400	(124)	40	(15)	291	(95)	20	(2)	2	(1)	753	(237)
Neurosurgery	34	(19)	3	(3)	30	(22)	3	(1)	13	(—)	83	(45)
Plastic Surgery	13	(8)	5	(3)	17	(15)	2	(2)	2	(—)	39	(28)
Thoracic Surgery	60	(42)	4	(2)	27	(19)	3	(1)	10	(1)	104	(65)
Traumatic and Orthopaedic Surgery ...	205	(113)	49	(25)	236	(135)	20	(11)	69	(6)	579	(290)
Ear Nose and Throat ...	95	(54)	11	(5)	71	(51)	20	(12)	33	(5)	230	(127)
Obstetrics and Gynaecology	271	(141)	23	(5)	277	(121)	363	(74)	109	(17)	1043	(358)
Others	69	(23)	74	(27)	199	(88)	15	(6)	37	(4)	394	(148)
Totals	3266	(1308)	853	(378)	2616	(1249)	839	(308)	1969	(385)	9543	(3628)

Where doctors were employed in more than one specialty at the time of the census they have been entered under the specialty in which they were mainly employed. Some doctors employed in certain specialties may be shown under a more general heading, for example some doctors working in urology may be included under general surgery. Many of the doctors shown under 'Others' were casualty officers.

The contribution made to the staffing of individual specialties by doctors born outside Great Britain is illustrated in the following diagrams. The diagram for each grade relates to those specialties in which more than 20 doctors are working in the grade.



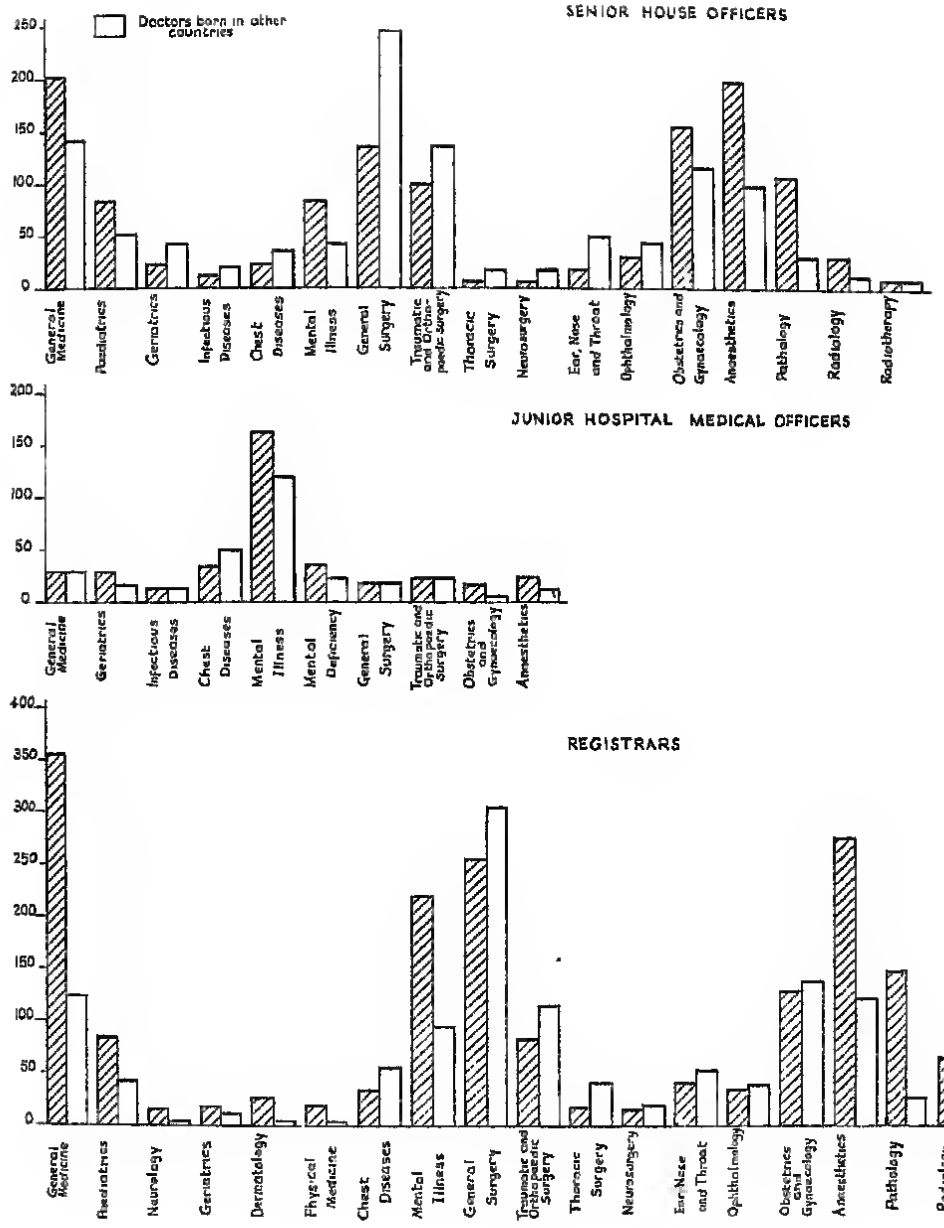


Table 5

Classification by Region and Grade

Region	Grade					Total
	Registrar	Junior Hospital Medical Officer	Senior House Officer	House Officer (fully registered)	House Officer (provis'lly registered)	
Newcastle	135 (75)	49 (23)	188 (116)	17 (8)	82 (18)	471 (240)
Leeds	145 (74)	52 (30)	118 (75)	42 (25)	89 (21)	446 (225)
Sheffield	198 (111)	37 (20)	185 (109)	2 (1)	72 (11)	494 (252)
East Anglian	92 (49)	10 (5)	51 (25)	16 (3)	39 (11)	208 (93)
Metropolitan Regions ...	1344 (509)	179 (81)	874 (430)	359 (136)	786 (169)	3542 (1325)
Oxford	98 (51)	23 (8)	65 (26)	31 (17)	51 (12)	268 (114)
South Western	72 (29)	69 (30)	146 (52)	24 (2)	82 (20)	393 (133)
Welsh	111 (40)	49 (23)	140 (69)	29 (7)	71 (10)	400 (149)
Birmingham	183 (86)	66 (41)	160 (84)	66 (33)	115 (26)	590 (270)
Manchester	240 (126)	76 (50)	251 (132)	46 (22)	132 (32)	745 (362)
Liverpool	210 (74)	43 (24)	127 (51)	27 (12)	83 (13)	490 (174)
Wessex	91 (32)	26 (8)	38 (16)	24 (4)	46 (11)	225 (71)
Scotland						
Northern	12 (5)	1 (—)	7 (1)	2 (—)	7 (—)	29 (6)
North Eastern	28 (3)	13 (1)	21 (5)	7 (1)	46 (3)	115 (13)
Eastern	31 (—)	8 (1)	27 (6)	11 (1)	38 (5)	115 (13)
South Eastern	102 (26)	23 (8)	64 (16)	60 (13)	81 (8)	330 (71)
Western	174 (18)	129 (25)	154 (36)	76 (23)	149 (15)	682 (117)
Total	3266 (1308)	853 (378)	2616 (1249)	839 (308)	1969 (385)	9543 (3628)

Table 6

Proportionate contribution to junior staffing in regions made by doctors from overseas.

Hospital region	*Proportion of total staff in the junior grades represented by doctors not born in Great Britain*
England and Wales	
Newcastle	51 per cent
Leeds	50 „
Sheffield	51 „
Liverpool	36 „
Manchester	49 „
Birmingham	46 „
East Anglian	45 „
Metropolitan (4 regions)	37 „
Wessex	32 „
Oxford	43 „
South Western	34 „
Wales	37 „
Scotland	
Northern	21 per cent
North Eastern	11 „
Eastern	11 „
South Eastern	22 „
Western	17 „

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